			For State Registrar	State	of Marylan	id / Depa	artmen rtificate	t of H	ealth a Death	and M		g. No.	005		
	Physicia	an	1. Decedent's Name (First, Middle Sibley M. Scl								2. Date of Death Februar		2 ប៊ីប៊ី 5	3. Time o	of Death PM M
	/Medic Examin	al	4a. Facility Name (If not institution Rockville Nu:	, give street and n				Town, or	Location o	of Death	TODICAL	4c. Co	unty of Deat	h	
×	Funeral Director		5. Social Security Number 213-48-8182	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. 97	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Oct 29,	Yeer) 1907	9. Birt Co Mi	hpiece (Stete untry) SSOUT i	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	City Limits
	Maryl	tor	MD Montg	omery		Rock	ville							1 ☐ Yes	s 2√ No
	or 284	Funeral Director	10e. Street and Number				10f. Zip	Code			10	og. Citizer	of What Co	untry?	
	eath w	erai	303 Adclare Ro		cedent Ever in U	S. 13.	Was Deced	ent of Hi	2085		ecify Yes or No-		USA Race - Ame	rican Indian,	
036	urs after d al', or item Exarcimen	b	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed 1 ☐ Yes	Forces? 2 21 No Bive		If Yes, spec 1 ☐ Yes		Specify:		ecify Yes or No- Rican, etc.)	Sp	Black, White	hite	
Maryland 21215-0036	72 ho	Completed	15. Deceden (Specify only highe	t's Education st grade completed	1)	16a. Dece	kind of wo	rk done d	luring mos	t of work	ing	16b. Kind	of Business/	Industry	
121	within ene. then	dmo	Elementary/Secondary (0-12)	College 2	(1-4or 5+)	me.	<i>וט אסד וטס</i> hot	ısewi	_			70	wn hom	e	
מפר	e filed al Hygi other vent,	Be C	17. Father's Name (First, Middle,		-						First, Middle, N	Maiden Su	тате)		
<u> </u>	ould b Ments larked	To B	Seth Doan Mer					1.			ne Antoi				
Mar	d 2 sh th and t7 is m traum		19a. Informant's Name/Relations Robert S. Schw		n		-				al Route Number. ockville	-	2085 , 2085		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow amportant: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow apprintury or other traumatic event, the Medical Exacting transities notified at another.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal fro	20b. I	Place of Dispo cemetery, crea	sition (Nan	ne of	1		-		tion - City or		
Balti	permit. Departm Departm Importat any inju		21. Sign turs of Euneral Service		Mr. Co	r Si	2. Name an tate 1 altimo	Anato	omy B	oard 2120	655 W.	Balt	imore	Street	
	* *		23a. Part 1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final	dnly one cause or	each line.	th. Do not en	ter the mod	e of dying	g, such as	cardiac (or respiratory arre	st,		Approxima Interval Be Onset and	etween
}	Physician /Medical Examiner		disease or condition resulting in death)		UMONIG o (or as a consec	quence of):									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due t	o (or as a consec	quence of):									
,092	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Due	o (or as a consec	quence of):							-		
687	ificate g phys as the			d	4						-/1/10-2	one of the same		ELOIL.	
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 Live	outcome of pregn birth 2 Feta gnant at time of concern	al death 3	∃Ectopic pr ∃ Other <i>(sp</i>					230	f. Date of de Month	ivery Day	Year
α.	ires that the death signed by the atte d be detached for	by	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	inderlying o	ause give	en in Part I		23e. Did tob		/	the cause of	death?
örc	w requir been si should	eted									24a. Was a			utopsy finding:	
Vital Records,		Completed									autops perform 1 Tyes 2	med? XI No	prior to death? 1 Yes	fo noiteliamos	cause of
	ysician: is certific director,	o Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	☐Inpatient 2□] ER/Outpatie	nt 3 🗆 DC	DA Dthe	an C A		h <i>(Check only on</i> me 5 ☐ Reside		Other (Spe	cify)	
ion of	ding Ph J. After th funeral	ation: T	27. Manner of Death 1 ⊠Natural 5 ☐ Pendi	/4.4	te of Injury onth, Day Yeer)	28b. Time of Injury	of 2	28c. Injury Work	/ at <br Yes 2 □		28d. Describe ho	w injury o	eccurred		
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Fla	ce of Injury - At h Iding, etc. (Spec	nome, farm, st	reet, factor	y, office			28f. Location (St. City or Town		vumber or A	ural Route Nu	mber,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	Medical (ng Physician: To Exeminer: On the and m											(s)
	To th withir To th comp	Me	29b. Signature and title of certific	Tourske	o Ma	y, Mix	290	c. License	519	16	2:	eh,	signed (Moni	h. Day, Year)	5
			30 Name and address of persor	/- A/	ause of death (Ite	m 23a) (Typer	Print)	, D.	ko	2-	100, Roc	kvil	/e, W.	10 20,	852
H _p	Sta Regist	ate rar	31. Date filed (Month, Day, Year) /32	Registrar's Sign	ature Span	le le	- 11	12/	V /		15.77		•/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Rosa 15:39 PM Tindel Fibruary 2005 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Raltimore 8. Date of Birth (Month, Day, Year) 4-15-08 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1□M 2/0F Hours 96 220-05-877 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits in then "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No MD MHIMOre 10e. Street and Numbe 10g. Citizen of What Country? SH Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1□Yes 2☑No Specify BIACK 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Signatury/Secondary (0-12) Callege (1-4qr/5+) Refired Union Memorial 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Ma NcFadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addr, ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. West St. Baltimore, MD lindel or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Battimore, MD -26-05 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaugen C Greene Funeral SNC. 21. Signature of Funeral Service Licens Kd. Kardalloto wx MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Killure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HASCVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) -fransit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No 2 6 ☐ Other (Specify) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel C
completely filled i Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belvedere Ave, Baltimore, -1 M.B. Au

Registrar

31. Date filed (Month, Day, Year)

32. Rastrar's Signature

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19, 2005 4:50 PM Mary Gunther Tilley February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 303 Whetstone Road Harford Forest Hill If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 😾 F 79 August 7,1925 | Maryland Director 216-20-7943 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 17 is marked other than "netural; or items 23a or 28e-f show treumatic svent, the Modical Examinar must be notified at treumatic svent. 1 ☐ Yes 2 No Maryland Harford Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Whetstone Road 21050 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than 'any fujury or other treumatic svent, Item 2002e. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron Melvin Gunther Mary Ellen Treadway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Whetstone Rd., Forest Hill, Maryland Dennis M. Tilley - Son 20a. Method of Disposition
1 ঐBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bel Air Memorial Grdn. 2/26/2005 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Som ture of Funeral Service 22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Road, Abingdon, Maryland 21009 apmas Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Immediate Cause (Final 20months Priysician OVARIAN CANCER disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Little Ur Jerging Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed the ettending physicien and ched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) detached ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes To the Mospitei or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home SEXResidence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerei C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) asallan M.D DA5530 02-22-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S ATWOOD ROAD, MD-21016 SULTE SIUASALLAM 200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06504 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 228 **Physician** Viar Robert Edward February ,2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Caryland General pital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 15, 1945 | North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 59 219-42-1803 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show 1 Yes 2 No **Funeral Director** Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. Joppa Road, Tabco Towers Apt 801 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. traumatic event, the Maylout Examination 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Highway Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fit ment of Health and Mental H tant; If item 27 Is marked ott Viar, Sr. 2 Walter Lee Daisy Ann Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 Is
any Injury or other trau 9956 Oak Terrace Road, Mardela Springs, MD 21837 Annie Short - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2-23-05 Hilltop Service Corp. Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each line. Immediate Cause (Final disease or condition resulting in death) Prysician OKONARI /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed lea Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4☐ Pregnant at time of death P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 this

Division

1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ipital: 1 Minpatient 2 ER/Outpatient 3 DOA
28a. D. te of Injury
(Month, Day Year)

28b. Time of Injury
Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Certification: 1 Natural 2 Accident 5 Pending 2 🗌 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

40 M.U. 31. Date filed (Month, Day, Year) 32. Register's Signature

Registrar

funeral

After

Director:

death.

after

24 hours a

within 2

the Hospital or Attending

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			- For Amend Item Registrer AMEND ITEM	State of M 3 per 1	Maryland F.,G8 TH G84	/ Depa 40,02/ 13/18/	rtment of H	lealth and Death	Mental Hyg	iene 005	06505
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Earl Louis Wagner						2. Date of Deat Month February		3. Time of Death M
	Examin		4a. Facility Name (If not institution, give Gilchrist Center	street and number	r)		4b. City, Town, or TOWS		h	4c. County of De Baltin	
	Funeral Director				Age (In yrs. Ia 34	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. E 920 Ma	lirthplace (State or Foreign Country) Yland
	show show	'n	Usual Residence of Decedent 10a. State 10b. County			. Town or Lo	cation				10d. Inside City Limits
	or 28a-f	Funeral Director	Maryland Baltimore 10e. Street and Number		GIE	en Ami	10f. Zip Code		1	0g. Citizen of What	1 ☐ Yes 2 No XX
	ems 23e	neral	· · · · ·	12. Was Deceder Amed Forces	s?		1	21057 ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ar Black, W	nerican Indian,
9800	ours after ral', or it	by	1 ☐ Never Married Married Widowed 4 ☐ Divorced	XXYes 2 If Yes, Give Year or Dates	No WWI	.1	☐Yes 2XXNo	Specify:	,		white
1215-0	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ther then "natural", or Items 23a or 28a-f show ant, the Medical Examinat must be profitted at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-40	r 5+)	(Give life. L	lent's Usual Occupi kind of work done of OO NOT use retired	during most of wo i)	rking	16b. Kind of Busines	ŕ
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If Itam 27 is marked other than "naturat", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinat must be notified at	To Be Co	17. Father's Name (First, Middle, Last) Louis Philip Wagner	5+			inance Mana		ARET WELRY Fret Welner	Manufactur KÜDE WEHN	
	1 and 2 shou Health and N tam 27 Is mai		19a. Informant's Name/Relationship (Ty Beatrice C Wagner	ре, <i>Print)</i> Wi	ife	19b. Mailin 4200 M	g Address <i>(Street a</i> lanor View F	and Number or Ri Road Glen /	Arm, Maryla	, City or Town, State nd 21057	, Zip Code)
Baltimore,	Pa In the land		20a. Method of Disposition **Malerial 2	emoval from Stat	Ce	metery, cren	sition (Name of natory or other place rest VA Cen	n 3/2/0	05 0	20c. Location - City Wings Mills	Maryland
Ball	permit. Pag Department Important: I any injury o		21 Signature of Funeral Solvice Licens Own Dept	in Ken	cake	ك	. Name and Addres			defeld Funen imore, Maryl	ral Home Inc Land 21212
	Physician		23a. Part1. Enter the disease for compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that causine pause on each	ed the death line.	Do not ente	er the mode of dyin	g, such as cardia 'Nolome	c or respiratory arre	est,	Approximate Interval Between Onset and Death
ı	/Medical Examiner		resulting in death) Sequentially list conditions	Due to (or a	as a consequ	ence of):					
V	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a consequ	ence of):					
,8760,	cate be executed physician and the burial-transit	dlcal Ex	resulting in death) Last	Due to (or a	as a consequ	ence of):					
O. Box 68	The law requires that the death certific: ate has been signed by the attending pl page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	elivery Day Year
rds, Þ	w requires that been signed b should be deta	by	Part II. Other significent conditions con	ntributing to death	but not resu	lting in the ur	nderlying cause give	en in Part I.			to the cause of death? Probably 4 OUnknown
Il Records,		Completed							24a. Was at autops perform	y prior t ned? death	autopsy findings available o completion of cause of
f Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	tient 2 🗆 E	R/Outpatien	3 DOA Othe	ar	ath <i>(Check only on</i>	e) ince 6 12 0ther (<i>Sj</i>	pecify) ND, FO (2.6
on of	ding Ph h. After th funeral	tlon: T	27. Manner of Death Panatural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time of Injury	28c. Injury Work	/ at		w injury occurred	
Division	in Line	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At hor etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (Sti City or Town		Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Dirticompletely filled in I	Medical (29a. Certifier Check gan 2 Medicel Exemi	sicien: To the bes ner: On the basis and manner:	of examinati	vledge, death on and/or inv	occurred at the tim restigation, in my op	ne, date and place pinion, death occu	e, and due to the ca arred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	Lu	>		29c. License	number 303) P	Od. Date signed (Mo	nth, Day, Year)
	6		2 1 0	wes.	\sim	23a) (Type,	Print) CU	revles S	ir Town	n, mo	23 205° Z1209
**	Sta Registi		31. Date filed (Month, Day, Year) FEB 2	32. Regis	strar Signat	ure &	Sparke	į			

		•	- State Amend Item 2:	State of Maryland / Dep Baper Dr., G840, %	partment of Health and Alle Death	Mental Hygi	ene) 005	06506
	Physicia	an	1. Decedent's Name (First, Middle, Last) YVONNE F. WILLIF			2. Date of Death Month		3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number) LYLAND HUSPITM	4b. City, Town, or Location of Dea BALTIMORE	th	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 084 -32-3339	M 284 F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Bin 941 No	hplace (State or Foreign untry)
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location			10d. Inside City Limits
	a-f sho	ctor	new York Westches	ter New R	ochelle			1 TyYes 2 □ No
	with the	Director	10e. Street and Number	1	10f. Zip Code	10	g. Citizen of What Co	untry?
	death ms 23	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. 13	080] B. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Ame	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once.	by	158 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Y Year or Dates:	If Yes, specify Cuban, Mexican, Puel 1 Yes 2 No Specify:	no Hican, etc.)	Specify: Black	e, etc. -K
15-0	"netur	leted	15. Decedent's Educ (Specify only highest grade	ation 16a. Der completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo . DO NOT use retired)	orking	16b. Kind of Business/	industry
21215-0036	d withir giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	use keeper	1	Nursing	Home
	be file ntal Hy od othe	Be	17. Father's Name (First, Middle, Last)	•	18. Mother's Na	me (First, Middle, M	faiden Sumame)	1
Maryland	should nd Mer marke	2	19a. Informant's Name/Relationship (Typ	e, <i>Print</i>) 19b. Ma	iling Address (Street and Number or R	Tural Route Number,	City or Town, State, 2	Zip Code)
	and 2 ealth a n 27 is		Steffvon William	rms 98	Livingston Place	e Brid	geport, (t. 06610
altimore,	Pages 1 nent of Ho int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	position (Name of ematory or other place)	Date	11	Town, State
altin	permit. Pa Departmer Important any injury once.	i	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	ternclit	+ Weingtory Mai	1ch 2,2005 1	tartsdale,	PA. Pork
ä	permi Depa Impo any ir		Carlden C. 7	tenfan	1701 Mc Cullah Si	+ Pallo	. led. 21.	217
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the death. Do not end a cause on each line.			est,	Approximate Interval Between Onset and Death
}	Physician Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Pneumonia	<u> </u>		
L	Examiner	_	Sequentially list conditions, b.	Due to (or as a consequence of):				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events	Due to (or as a consequence or):				
30,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
68760,	cate phys	edical	d					
Вох	death certifi e attending p id for use as	an/M	230. Was decedent pregnant	ac. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death	B □Ectopic pregnancy		23d. Date of del	,
.O.	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown		Other (specify)		Month	Day Year
s, P.	The law requires that the tite has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ords	w require been sig should b					1 ☐ Ye	s 2, Mar No 3 ☐ Pr	obably 4 Unknown
Record	ne law s has b ge 2 sł	ompleted				24a. Was ar autops perform	y prior to	stopsy findings available completion of cause of
Vital		e C	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2	No 1 Yes	2 ⊠ No
of V	this al dia	ToB	TE TOS ZACINO	ospital: 1 In patient 2 ER/Outpat			nce 6 Other (Spe	cify)
	flng After fune	tlon:	27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe ho	w injury occurred	
Division	- 9 -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
	pital or ours afte leral Dir filled in		29a. Certifier 1& Certifying Phys	ician: To the best of my knowledge, de		and due to the on	uca(c) and manner as	etatod
	To the Hospital of within 24 hours aft To the Funeral Discompletely filled in	edical	(Check only 2 Medical Examin	er: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	curred at the time, da	ite and place, and due	to the cause(s)
	Within To the	Σ	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Mont	
			30. Name and address of person who co	moleted cause of death (Item 23a) (Tur	P (7668		FEB 24	, was
			C. HUYNH, MD 1	6 SOUTH EVITAW ST	BALTIMORUE MD	21201		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 8 2005	32. Registrar's Signature				

Box 68760,	
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Division o	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** 11.30 AM Williams Susie 2 05 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth BALTIMORE SAMARITAN NA HOSPITAL 6,00 D 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NT C 5. Social Security Number 6 Sex **Funeral** 1□M 2⊠F 72 N.C. Director 219-26-6483 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show event, the Medical Examiner must be notified at X□Yes 2□No Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 1224 N. Ellwood Ave. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 12th grade 17. Father's Name (First, Middle, Last) Nurse's Aid Fayette Convalescent 18. Mother's Name (First, Middle, Maiden Sumame) Williams Louis Newell other traumatic ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1224 N. Ellwood Ave., Baltimore, Md. Modestine James Daughter 20a Method of Disposition 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removat from State
4 Donation 5 Other (Specify) 0 permit. Page Department of Important: If any injury or once. 2-28-05 Randallstown, Md. King Mem. Park 21. Signature of Funeral Service Licenses-22 Name and Address of Facility Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic oregnancy detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by 8 HYPERTENSION 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performs 1 Yes 2 No Attending Physician: Be 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Thipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 YNo 2 ER/Outpatient 3 DOA Certification: To in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred after death. 5 Pending investigation 1 Natural Injury Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. RES 000 05 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 5601 ZEEBA MATHEWS LOCH RAVEN BOULEVARD. BALTIMORE MD 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 8 2005 Registrar

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1.	J 4 0			State of Maryla	nd / Dena	ertment of l	Health and I	Mental Hyd	iene	
		ľ	1 - For State Registrar amend item#	\$1		rtificate of			g. No. 0 0 5	06508
	- · ·	vi)	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dear		3. Time of Death
	Physici /Medic		Brenda Lorraine	Williams	William	8			RY 21, 200	
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County of De	ath
			JOHNS HOPKINS HOS 5. Social Security Number 6. S		s. last birthday)	BALTIM If Under 1 Year	ORE CITY If Under 24 Hrs.	8 Date of Birth	NA NA	irthplace /State or Fernias
	Funeral Director			□M 2XF 42	Yrs.	Months Days		8. Date of Birth (Month, Day 2-23-6	Year) (irthplace (State or Foreign Country) Md.
)	pu ,		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo					
	f show	ō	Md. NA	100.	Balti					10d. Inside City Limits 1 X Yes 2 ☐ No
	28a-	rect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show ta Madical Examirer must be rediffed at	Completed by Funeral Director	1406 Aisquith St	reet			202		USA	,·
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	Hispanic Origin? (S can, Mexican, Puert	pecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
36	s afte	y Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2 🛣 No		- · · · · · · , • · · · · ,		Black
21215-0036	houn tural	ed b	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occu	nation		16b. Kind of Busines	s/Industry
7	nin 72 In no	plet	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor ad)	king	TOD. THING OF DUSINOS	aviilousti y
21	ed with	Com	10th grade	Obliege (1-401-34)	Car	pentry			Varies	
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, i		
<u>ya</u>	d Men narke	5	Charles		illiams		Carri		Whetstor	
Maryland	id 2 slith and 12 slith and 12 string 12 strin		19a. Informant's Name/Relationship (Daughter			h Street,		City or Town, State	21202
	f Hea item	3	20a. Method of Disposition	206	. Place of Dispo	osition (Name of matory or other pla			20c. Location - City of	
E	Page nent o int: If iry or		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify				rden 2-2	8-05	Dundalk, M	1d.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, If a Madical Examinet must be notified at 2008.		21. Signature of Funeral Service Licen	1960		2. Name and Addr		Balt	imore, Md.	. Md. 21202
	20 E 20		1	Herry		March F.			. North Av	
			23a. Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	-3			or respiratory arr	est,	Approximate Interval Between Onset and Death
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В	Examiner				equerice or).					
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687				d						
Вох	death certifica e attending ph id for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred		∃Ectopic pregnanc	214		23d. Date of d	
O. B	e deat he att	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time o		Other (specify)			Month	Day Year
<u>Р</u>	hat the	Phy	9 Unknown Part If. Other significant conditions of		esulting in the u	nderhina cauce a	won in Bart I	23e Did to	Dacco use contribute	to the cause of death?
ds,	as ng	d by	Partil. Other significant conditions of	Shiributary to death but not i	esalang in ale a	iliderlyllig cause gi	Well III Pail I.			Probably 4 Unknown
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Re	The law cate has page 2	Completed						autops	y prior to ned? death?	completion of cause of
Vital		BeC	25. Was case referred to medical				26. Place of Dea	1 Yes		35 2 140
of V		P	examiner? NXYes 2 □ No		☐ ER/Outpatier	IL SEL DOA		lome 5 Reside	4	oecifyAt Scene
	ding P	lon:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury Fnd (Month, Day Year,	Fndjury	Wo		28d. Describe ho	ow injury occurred	unk
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<u>S</u>	alor/s after	Certification:	4 Homicide	e 28e. Place of Injury - A building, etc. (Spe found at h	ome	,,,		BAltimo	^{1, State)} 724 N	Kenwood Ave
	To the Hospital or Attending Physical advances after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical ((Check only XX Medical Exar	nysician: To the best of my k	nowledge, deat	h occurred at the t	time, date and place	, and due to the c	ause(s) and manner	as stated.
	thin 2 the l	Med	one) 29b. Signature and title of certifier	and manner stated.			ise number		9d. Date signed (Mo	
	5 × × × ×		1	111		OCM			FEBRUARY 2	
			30. Name and address of person who	completed cause of death of	ern 23a) (Type.	Print)				
			THE WORE MI	ling		111	Penn Str	eet Bal	timore, Ma	ryland 21201
:-	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig 8 2005	gnature	dist.				
	ricgist	121	FER /	A / (111) ■ #E& at. a.	5 9	ALC: NO THE PARTY OF				

Amend is the of Maryland Separtment of Health and Mental Hygiene 0 5 06509 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6,ްÖ′05 **Physician** Mary Elizabeth Waynes February 3:00pm/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Locetion of Death Examiner Takoma Park
If Under 1 Year If Under 24 Hrs. <u>Adventist Hospital</u> Montgomery Washington 9. Birthplace (State or Foreign Country) 6 Washington 7. Age (In yrs. la 6 9 8. Date of Birth (Month, Day, last birthday, **Funeral** Days Hours Min. 1 □ M 2 **S** F Months 17,1936 Director 579-46-3227 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show r than "natural", or itema 23a or 28e-f shov the Medical Examiner must be routiled at ₩ wes 2 No Director Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5934 13th Place 20011 NW #1 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ♣ No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 y r S Elementary/Secondary (0-12) Computer Specialist Private permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other then pluy or other traumatic event, The ODE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Coates George E. Cotes Daisy Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5934 13th Place NW #1 Washington, DC 20011 Beatrice E. Bumbry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) Riverdale Crematory 2/11/05 Riverdale, MD 21. Signature of Funeral Service Licensee 2AUSTITAddrRoystver Funeral Home 3821 14th St. NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lamediate Cause (Final disease or condit in resulting in death) Filysician Sepsis /Medical Due to (or as a consequence of): Examiner Line Related Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Il-transit To the Hospitel or Attending Phyaician: The law requires that the death certificate be executed End Stage Renal Disease physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ⊋Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving St. NW Washington, DC 20010 Cosette Jamieson 31. Date filed (Month, Day, Year)
FEB 2 8 2005 2. Registrar's Signature Registrar

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			1 - For State Registrar	State of it	iai y tarre	-	tificate of D			eg. No.	005	05510
			Decedent's Name (First, Middle,)	Last)					2. Date of Deat	h		3. Time of Death
	Physicia /Medic		Mary J. V	Wright				I	Month Tebruar	Day V 1	9 2005	0825 M
	Examin		4a. Facility Name (If not institution, g	give street and number	7)		4b. City, Town, or I	ocation of Death		4c. (County of Dea	th
			Anne Arunde1 5. Social Security Number 6		Cente		Annapo If Under 1 Year	lis If Under 24 Hrs	8. Date of Birth		ne Arı	
	Funeral Director		212-36-4241	1 M 2CXF	80	Yrs.	Months Days	Hours Min.	Sept. 1	Year)	9. 0. 9. 0. 0. 9. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.	thplace (State or Foreign buntry)
			Usual Residence of Decedent						gept. I	/ 1	J2 # 110	
aryiar	show	-	10a. State 10b. County		10c. City.	, Town or Lo	cation					10d. Inside City Limits
he M	28a-f	ecto	Saryland Anne 1	Arundel	Anr	napo1				0- 033		
with	l ber	Funeral Director		O 1			10f. Zip Code		'	og. C1112	en of What Co	
death	me 23	era	142 O'Berry (12. Was Deceden	t Ever in U.S	3. 13.	21401 Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp	pecify Yes or No-	1	US A 4. Race - Ame	erican Indian,
after	or ite	교	1 Never Married 2 Married	Armed Forces d 1 ☐ Yes 2 1 1 1 Yes, Give			TYes, specπy Cuban 1 □ Yes 2.□.No	Specify:	Hican, etc.)		Black, Whit	
III Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	"neturel", or iteme 23a or 28a-f show edical Examinar must be nutified at	d by	3 ⊈Widowed 4 □ Divorced	Year or Dates	:						Specify: B	
0.721	"net	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion Iring most of work	king	16b. Kin	nd of Business	/Industry
with	iene.	omp	Elementary/Secondary (0-12)	College (1-4or	r 5+)		omestic			Dri	wato I	Eamilies
	othe vent.	Be C	17. Father's Name (First, Middle, La	ist)	ŧ			18. Mother's Nam	ne (First, Middle, M			duilles
should b	and Mental Hygiene. is marked other than eumatic event, It a Me	To	Alfred Ma	ack				Georg	gianna	Sno	wden	
2 sho	if Haalth and Mental Hygiene. Item 27 is marked other than "natur other treumatic event, It a Mcdical		19a. Informant's Name/Relationship		,		ng Address (Street ar					
and z	of Haalth item 27 other tre		Mary A. Hall 20a. Method of Disposition	(Daughter	20h BI	age of Diene	Eastern				Md	
S	nt of It. If it.		1 ☑ Burial 2 ☐ Cremation 3		e Mai	metery, crer cvlan	matory`or other place d Vetera	n la ca				
Tit. P	Department of Important: If i any injury or once.		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie 		Cer	nête r	Name and Address	Z/Z8 of Facility	B/05	Cro	wnsvi.	lle, Md.
o ē	Depa Impo any ir		Larry Hi	Riese MO	. 61510	2 W	m. Reese	S Sons	s Mortu	ary	F.A.	
			23a. Part1. Enter the dilease, or conshock, or heart failure. List or	omplications that cause	ed the death	. Do not ent	er the mode of dying	such as cardiac	or respiratory arre	est,	d. 21	Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	K	0.5	2	Dad	we				Onset and Death
	Medical caminer		resulting in death)	Due to (or a	is a consequ	ence of):<-	7/1	- 11	00 =			5
_^	.aminer	<u></u>	Sequentially list conditions,	b. Due to Oct d	a consequ	NO F	rolul	11/0	Milia			000
petr	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	is a consequ	onog orj.						
ou, be executed	nysician and he burial-transit		resulting in death) Last	C. Due to (or a	is a consequ	ience of);						
9	ysicia he bu	icai		d.								
ertifica	ling pl	Physician/Med	IF FEMALE:	00-14								
DOX	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3	Ectopic pregnancy Other (specify)			2	3d. Date of de Month	livery Day Year
j	y the	ysic	1 Yes 2 No 9 Unknown	9□ Unknown		32						
The law requires that the death certifica	been signed by the attending phi should ba detached for use as th	by Pi	Part II. Other significant condition	s contributing to death	but not resu	ilting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco us	se contribute to	o the cause of death?
w requires	been sig should b	ted t	arrol & DI	Maria	-)_	Ma	to cot co	ma	1 □ Ye	s 2 🖁	PNo 3□P	robably 4 Unknown
a w	S C/	ompieted	V						24a. Was a	y		utopsy findings available completion of cause of
	n. After this certificate has b tuneral director, paga 2 s	Con							perform 1 Tes 2		death? 1 ☐ Yes	2 No
Vital	certifi	Be	25. Was case referred to medical examiner?	Hospital:					th (Check only on			
2 ਵ	ar this aral di	7; To	1 ☐ Yes 2 👰 No 27. Manner of Death	28a. Date of In	jury	28b. Time o	f 28c. Injury	at	ome 5 ☐ Reside			ocify)
nding	ath. r: Afte e tun	atlo	1 ■Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E	Day Year)	Injury	Mork' M 1 □ Y	es 2 No				
r Atte	rector; by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. FIACE OF	njury - At ho	me, farm, sti	eet, factory, office		28f. Location (St. City or Town	reet and	d Number or R	ural Route Number,
2 :	rrs aft ref Di lled in		<u> </u>									
To the Hospital or Attending Physician:	within 24 hours after death. To the Funerel Director; A completely filled in by the fu	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E.	Physician: To the bes xaminer: On the basis and manner:	of examinat	wledge, deat ion and/or in	h occurred at the time vestigation, in my opi	e, date and place, inion, death occur	, and due to the ca rred at the time, da	ause(s) a ate and	and manner a: place, and due	s stated. e to the cause(s)
o the	onple	Mec	29b. Signature and title of pertifier	and marrier	512160.	\cap	29c. License	number	2	9d. Date	signed (Moni	th, Day, Year)
-	10		> Emil H	yhil -	Sm	7	tron	0945	3	tel	Hur-	7000 466
7	6		30. Name and address of person w	no completed cause of	eath (Hem	23а) (Туре.	Print) A	10	/		. 0	100000
سعن			BXICOFAIP	MILLEDA	~1)	200	Bully	well	rmy, A	no	MY	21401
	Sta Registi		31. Date filed (Month, Day, Year)		strar's Signat	dos.	D		•			

	Please	Type or Print State of Man				_	_	le.
	1 - For State Registrar	0.0.0		rtificate of			Reg. No.	0 0001
Physician /Medical	1. Decedent's Name (First, Middle, La. Malcolm G. Wen					2. Date of Dea	Day	Year 12.30
Examiner	4a. Facility Name (If not institution, give WMNRYLROD HER) 5. Social Security Number 6. S	LTH CARES	SYSTEM In yrs. last birthday)	PERRY	Point If Under 24 Hrs.	8 Date of Birt	4c. County of	9 Rithplace (State or Fo
Funeral Director		£ M 2□F 80		Months Days	Hours Min.	8. Date of Birt (Month, Da Jan. 04	-1925	Michigan
fied at	10a. State 10b. County		oc. City, Town or Lo Parkvi					10d. Inside City L 1 ☐ Yes 2
s with the sa or 28e at the nutility of the sa or 28e at the nutility of the sa or 28e at t	10e. Street and Number 3300 Appleton Ave	• >		10f. Zip Code 212	34		10g. Citizen of Wh	nat Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time X7 is marked other than "natural; or items 23s or 28s-f show important: If item X7 is marked other than "natural; or other traumatic event, It is M-cital Examinat nust be nutified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 11 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hit Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race Black, Specify:	- American Indian, , White, etc. White
within 72 ho iene. rthan "natur ire Moralli ompleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	ng	16b. Kind of Bus	Service
tal Hyg d other event,	17. Father's Name (First, Middle, Last	1			18. Mother's Name)
Ments Ments Marked Marice	Harry Wentwor		40L M-18	6 11 (Chron		Turner		Note Zie Codel
and 2 sn ealth and n 27 is rr	19a. Informant's Name/Relationship (Beth C. Lyons / D	aughter	3300	Appleto	and Number or Rura n Ave., Ba	lto.,M	d. 21234	
Pages 1 ment of Ho ent: If iter ury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special	y)	20b. Place of Dispo cemetery, cre	matory or other play		2-/0 s'		Sity or Town, State
permit. Depart Import any inj once.	21. Signature of Funeral Service Lice	1588		2. Name and Addre	ss of Facility nton—Matth w Spring R	ews Eur	neral Hor	re. Inc.
Physician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence of):	ructive	. Pulmon	ary l	Diseas	C UN K'N C
eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examiner		C. Due to (or as a c	consequence of):					
the the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc	/		23d. Date Mont	of delivery h Day Yea
tuires that the signed by and be detacted by a detacted by	Part II. Other significant conditions	contributing to death but	not resulting in the t	inderlying cause giv	ren in Part I.			oute to the cause of dea
The law requir						24a. Was autor perfo	osy pr rmjed2 de	ere autopsy findings avaior to completion of causeath? Yes 2 No
ertifi ector Be	25. Was case referred to medical examiner?	Hospital:		O+1	26. Place of Death	(Check only o	nne)	
hys this at dii		28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Inju	v at 2		dence 6 Other	
tend Seath tor: the the	2 Accident investigation 3 Suicide 6 Could not to determine to	OB Place of laius	y - At home, farm, st (Specify)			28f. Location (S City or Tox		r or Rural Route Numbe
in in in	29a. Certifier Certifying P (Check only one)	hysician: To the best of miner: On the basis of e and manner state	xamination and/or in					
To the Hos within 24 h To the Fur completely	29b. Signature and title of certifier	and manner state	id.	29c. Licen:	se number		- 1	(Month, Day, Year)
4	5.5	od by		Dr	12014		rebrua	ry 17,2000
5	30. Name and address of person who	completed cadse of dea	ith (Item 23a) (Type	Print) NO NERI	TH CARE.	SYSTE	m. PERI	RY POINT, M
State	31. Date filed (Month, Day, Year) FFR 2 8 200	32. Registrar	s Signature	AP D	.,. 0.110			-1-1-1-1-

			1 - For State Registrar		State of	Marylar		artmen rtificate				lental Hy	giene Reg. No.	00	5	06512
П	Physicia	an	Decedent's Name (First,	Aiddle, La		,			/.	,		2. Date of De Month	ath Day)	rear	3. Time of Death
	/Medic		SEUNG		KWAM				AN			February	27	20	201	03.03 AM
	Examin	er	4a. Facility Name (If not inst	_						Location		3 .	4c. (County of	Death	
			The Johns 5. Social Security Number	6.9	Sex 7	PITAL Age (In vrs	last birthday)	I7 A		MonE			rth		Dietho	lace (State or Foreign
	Funeral Director		212 08 1094	0	1 ½ M 2□F	48	Yrs.	Months	Days	Hours	Min.	Aug 17	Year)	56	Kor	nace (State of Foreight (try)
	ט		Usual Residence of Decede									1				
	anylan show	٠,	10a. State 10b. Co	unty			ty, Town or Lo								1	Od. Inside City Limits
	Se-1:	cto		ward	l	El	llicott									1 ☐ Yes 2 🔀 No
	with th		10e. Street and Number					10f. Zip					10g. Citiz			,
	eath one 234	eral	8520 Ellicot	. Vie	W ROAC	ent Ever in II	18 13 1	Mas Dood	210		igin? (Sp	onify Voc or N				ates an Indian,
' O	r Item	Funeral Director	1 Never Married 2	Married	Armed Ford	es? N⊽ No	10.1	f Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)			White,	
21215-0036	within 72 hours atter death with the Maryland ene. Then "naturel", or Iteme 23a or 28e-f show the Medical Externity transities inclined at	by	3 ☐ Widowed 4 ☐ Div	-	If Yes, Give Year or Da			1 ☐ Yes 2	2 ⊡ ₩0	Specify:			3	Specify:	As	ian
2-0	72 ho	Completed		edent's E	ducation ade completed)		16a. Deced	kind of wor	k done a	lurina mos	t of work	ina	16b. Kin	d of Busi		
7	nithin ne. hen	mpl	Elementary/Secondary (0		College (1-	for 5+)	life. I	DO NOT us -	e retired,)		9	T		CI	
	lied w lygier ther ti	Co	17. Father's Name (First, Mi	ddle I act	4		<u> </u>	Owner		19 Mothe	or's Name	e (First, Middle		uor		re
and	d be funtal h	Be c	Kwang Suk Yar		/								, Maidell S	ournaine)		
Maryland	shouls od Me mark matk	10	19a. Informant's Name/Rela		Type, Print)		19b. Mailir	na Address				g Lee al Route Numb	er. City or	Town. St	ate. Zio	Code)
	alth ar 27 le r trau		Mi Won Yang/V		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							d Ellic				
re,	s 1 and the state of the other		20a. Method of Disposition			1 ,	Place of Dispo	sition (Nam	e of			Date				wn, State
E	Page net c int: tf		1 XBurial 2 ☐ Crema 1 4 ☐ Donation 5 ☐ Oth			are	est Law	-			3-1-2	2005	Marr	iott	svi	lle, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens. Importent: If tem 23e or 28e-1 show any injury or other traumatic event, the Medical Exertment in India at any injury or other traumatic event, the Medical Exertment in India at ange.		21. Signature of Funeral Se	1.()	moto	M008	4	<u>112 0</u>	ld_C	olumb	oia 1	<u>Pike El</u>	licot	's F t Ci	ami.	ly FH Inc. MD 21043
	Pnysician /Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	e, or corr List only	one cause on ea	on line.	quence of):					or respiratory a	rrest,			Approximate Interval Between Onset and Death
0	Examiner			- [ras a consec uv 6	ulence of): CAN									2 44
		er	Sequentially list conditions, a y, leading to immediate cause. Enter Underlying Cause (Disease or injury	J	D	as a consec		CFI							-	3 MONTHS
	od id ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	1	c											
o`	en an	Exa	resulting in death) Last	F		r as a conseq	quence of):									
8760,	icate be executed physicien and s the burial-transit	lical		-	_ d.										_	
9	The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE:	1	22a If year outer										- Hi	
Вох	attend tor us	lan	23b. Was decedent pregnation the past 12 months?	ot		n 2 ∏ Feta nt at time of c	al death 3	Ectopic pre					23	ld. Date of Month		ry Day Year
o.	that the de led by the a detached	yslo	1 □ Yes 2 □ No 9 □ Unknown		9☐ Unknov		10a(ii 5 _	JOTHAL (SPE	city)							
<u> </u>	res that igned b	by Pr	Part II. Other significant co	nditions o	contributing to dea	th but not res	sulting in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	e contribu	ute to th	e cause of death?
rds,	n sign											₩ Ç	Yes 2□	No 3	☐ Proba	ably 4 Unknown
Vital Record	law requir as been si 2 should	Completed										24a. Was		24b. We	re autop	osy findings available
Be	The lay te has	mo											rmed?	prio	r to con th?	npletion of cause of
ital		BeC	25. Was case referred to me	dical						26. Place	of Death	1 ☐ Yes	2 No		Yes	24 No
	Physicten: r this certifica ral director,	To	examiner? 1 ☐ Yes 2 🔀 🗸 🗸				ER/Outpatien	t 3□ DO	Othe	^{r:} 4□ Nu	rsing Ho	me 5□Resi	dence 6	□Other ((Specify)
Division of	or Attending Phatter death. Director: After th	Certification:	2 Accident in	ending vestigatio	n	Injury Day Year)	28b. Time of Injury	M 28	c. Injury Work 1 Y	at ? ′es 2 □ l		28d. Describe	how injury	occurred		
ΟİΧΪ	Itet or Att ins after di ral Direct led in by t			ould not be termined	286. Place 0	f Injury - At he p, etc. <i>(Specif</i>	ome, farm, stre	et, factory,	office			28f. Location (: City or To	Street and vn, State)	Number	or Aural	Route Number,
	To the Hospitet or Attending within 24 hours after death. To the Funeral Director: After completely tilled in by the funeral completely tilled in the funer	Medical	(Check only 2 Mei	lical Exar	nysician: To the b miner: On the bas and manne	is of examina	owledge, death ation and/or inv	estigation,	in my op	inion, dea	d place, a	ed at the time,	date and p	lace, and	d due to	the cause(s)
	To wit	~	29b. Signature and title of co	n anıer ≰	0-1	м	EDICAL OCCTOR		License				29d. Date	signed (A	vionth, E	vay, rear)
	71		Muly	in	ingui	no	DOCTOR		(LES	5-00	0		Echrus	ary 2	27	2005
	9		30. Name and address of pe									Ar Art -	BALTIA	•		m m His
	Sta	te	CHRISTOPHER 3 31. Date filed (Month, Day,	ear)	32. 20	istrar's Signa	TOHNS HO	4 KINZ	rios P	TAL	600	NORTH L	uolfês	INFE	!	21287
	Registr		FEB 2	8 20	005	ر مدین	S. As	ade								

			1 - For State Registrar	State of Ma	aryland / De	partment o		and Me		_ 2 U U 5	06513
			Registrar Name (First, Middle, La	st)		- Innoate t	or Dealir	2	Date of Death	g. No.	3. Time of Death
	Physici	an		·					Month	Day Year	14
3	/Medic		Charles David 4a. Facility Name (If not institution, give			4h City Toy	vn, or Location of		ebruary	/ 13 2005 4c. County of Dea	6:30 P M
*	Examin	ier							•		
	Funeral		Clearview Nurs 5. Social Security Number 6. S		e (In yrs. last birthda	y) If Under 1 Y	agerstov ear If Under:		Date of Birth		nington
	Funeral Director			X M 2□F	74 Yrs.	Months D	ays Hours		Date of Birth (Month, Day,		thplace (State or Foreign ountry)
			Usual Residence of Decedent					ΨE	c.3,19	DO Mai	yland
	nylan how		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	a-f.	cto	Maryland Wash	ington	S	harpsbu	rg				1 ☐ Yes 2 X No
	ath with the Marylan 23a or 28a-f ehow	Directo	10e. Street and Number			10f. Zip Co	de		10	g. Citizen of What Co	ountry?
	15 wi		5400 Mondell R	oad			21782			USA	
	dea dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Decedent		gin? (Specif	y Yes or No-	14. Race - Ame	
9	afte or it	<u>F</u>	1 Never Married	1XXYes 2□1 If Yes, Give	¹⁰ 1948	1 ☐ Yes 2X		, 1 4010 1110	A11, 010.)	Black, Whit	le, etc.
Ö	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow disal Examinat must be undified at	d by	3 Widowed 4 Divorced	Year or Dates:			no opeany.			Specify:	White
<u>~</u>	- 3	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dec	cedent's Usual Or ve kind of work do . DO NOT use re	ccupation one during most	of working	10	6b. Kind of Business	/Industry
12	d within piene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5	1+)					11 1	
7	7 7 -		17. Father's Name (First, Middle, Last,	1		ssemble		de Nome //		andblastir aiden Sumame)	ng Equipment
ğ	e d ai	Be		•							
Maryland 21215-0036	d 2 should the and Ment 7 is marked treumatic	은	Guy Lee Allen 19a. Informant's Name/Relationship (Type Print)	10h 14a	ilian Addana /Ct				nia Knight City or Town, State, .	
Ma	12 har										
	The The		Guy D. Allen - S 20a. Method of Disposition	on	20b. Place of Dis	O Monde	of	harps		Maryland Oc. Location - City or	
ē	ages nt of t: If It		XBurial 2 ☐ Cremation 3 ☐		cemetery, ci	ematory or other	place)				
Baltimore,	it. P.		*4 □Donation 5 □ Other (Specifical Light) 5 □ Other (Specifical Light)							Sharpsbur	g,Maryland
Ba	permit. Pages : Department of t Importent: If Ite any injury or ot once.		21. Signature of purioral service Live	(1)		22, Name and A SDORNE					21795
			23a Part 1 Enter the disease or com	nlications that caused	the death. Do not a	25 S. Co	onocoche	ague	St. Wil	liamsport	, Mary land
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir			dying, such as t	Jai Glac Of It	aspiratory arres	ι,	Interval Between Onset and Death
>	⊬nysician /Medical	8 1	disease or condition resulting in death)	a		nanz					(work
1	Examiner				a consequence of):						-
		- a	Sequentially list conditions, if any, leading to immediate	D	a consequence of):	un 1-	even				30
	uted Insit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Ć,	execi n and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	icate be executed physician and the burial-transit			d							
Õ	ifficat g phy as th	Physician/Medical									
Вох	death certific e attending p id for use as i	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		O=				23d. Date of del	ivery
	deati e atte	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		□Ectopic pregna □ Other (specify				Month	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9□ Unknown							
	requires that een signed b nould be deta		Part II. Other significant conditions of						23e. Did toba	cco use contribute to	the cause of death?
ğ	w require been si should b	ed	chunic Ani	ma co	hunic	men	\		1 🗌 Yes	2 No 3 Pr	obably 4 Hinknown
of Vital Records,	aw as b 2 st	plet	in Michely						24a. Was an	24b. Were au	topsy findings available
Ě	0 - 0	Completed by							autopsy performe 1 Yes 2	d? death?	completion of cause of
ita		Bec	25. Was case referred to medical examiner?				26. Place	of Death (C	heck only one)	, 2100	2010
<u></u>	Physician r this certific ral director	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Outpati	ent 3 DOA	Other: 4 LNur	Sing Home	5 Residence	ce 6 □Other (Spe	cify)
	ding P h. After t funera		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y 28b. Time Year) Injury	of 28c. I	njury at Work?			injury occurred	
sio	Attending r death. sctor: After by the fune	cati	2 ☐ Accident investigation	1		М	1 ☐ Yes 2 ☐ N	io			
Division	i or Atten after deat Director: I in by the	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	iry - At home, farm, : :. (Specify)	street, factory, off	ice	28f.	Location (Stree City or Town,	et and Number or Ru State)	ıral Route Number,
	pitel or Atten ours after deat lerel Director: filled in by the			1							
	Hos Fur ely	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best on niner: On the basis of	examination and/or	ath occurred at the investigation, in n	e time, date and ny opinion, death	l place, and n occurred :	due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner sta			ense number			. Date signed (Monti	
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			30. Name and address of person who		eath (Item 22a) (To-	Print\					
3	45+1		VASANT DATT	MD 34	o MILL	5-7 17	thers	70W	~ ~	0217	× 8
Ĭ	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature						
	Registr		FEB 15	2005	in A.	Joans Las					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9 **Physician** February РМ Mary Elizabeth Allen 2005 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Somerford Place Columbia 8. Date of Birth (Month, Day, Ye If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2X F 86 Maryland Director 212 10 0411 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23e or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Directo Columbia MD Howard the 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code with 8220 Snowden River Parkway 21045 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No. Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical County Board than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. 12 Secretary of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Kolzbach Mary A. Smardon ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betsy Allen/Daughter 44 Bay View West Selbyville, DE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Importent: If It any injury or o once. ment of 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 2-14-2005 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEIMER'S Immediate Cause (Final disease or condition **Physician** YEARS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien ar Due to (or as a consequence of): Box 68760. Physiclan/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2X No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 90 2 X 0 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page this certificate 1 Yes 2 No Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: $_{4\,\square\,\text{Nursing Home}}$ 5 $_{\Box}$ Residence 6 $\underline{\text{M}}$ Other (Specify) asst. livg ပ 1 ☐ Yes 2 ☐XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 □ Yes 2 □ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 27-394 February 10, 2005 30. Name are address of person who completed cause of death (Item 23a) (Type, Print) CHARDSON MO 201 EAST UNIV. PKWY "415 BANTO. MD 21218 32. Registrar's Signature 31. Date filed (Mon State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jacqueline Argerakis February 9, 7:00 a M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2704 Finch Street Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 14, 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Hours 1 □ M 2 🕅 F New York 77 Yrs. 577-34-2005 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2704 Finch Street 20902 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene.
Is marked othar than "natural", or Itel 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 AWidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Teacher's Aide Education injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alvin Norquist Hazel Mullum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is m any injury or other traum Nicholas A. Argerakis/Son 2704 Finch Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 14 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2005 ¹ 4 □ Donation 5 □ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Liver Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hepatitis C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, β 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1 Yes 2 X No 1 TYAS Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other 1 ☐ Yes 2 🔀 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Diractor: Atter ti 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 🄼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 12703 auson February 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Joseph Richards, M.D. 10301 Georgia Avenue, #203, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 0 2005 Registrar

e e		1	For State Registrar	e (First, Middle			Maryl	and / Dep <i>Ce</i>	artmer ertificat			and M	lental Hy	Reg. No.			5516
/Mi	siciai edica mine	r	a Facility Name (Hospit	, give stree a1	t and num	No.		CUMB	ERLA			Month FEBRUA	4c. Al	200 County of I LEGA	Death NY	:53 ™
Fune Direct		2	5. Social Security N 233-78-49 Usual Residence o	26	6. Sex 1 ☐ M	≥	Age (m)	vrs. last birthday Yrs.	Months		If Under:	Adin	8. Date of Bir Month, Pa Apr. 1	3, 19	943	Birthplace (S	State or Foreign
Maryland e-f show			10a. State	10b. County Hampsh	nire			City, Town or L Romney	ocation								ide City Limits Yes 2 No
th with the 23a or 28		runeral Director	10e. Street and Nu 15 Indi		ghts C	Circl	e		10f. Zip	Code 6757				10g. Citi:	zen of Wha	t Country?	
5-0036 72 hours after death with the Maryland neturel', or Iteme 23a or 28e-1 show		2	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		ed 1	Vas Deced Imed Ford Yes 2 Yes, Give Year or Dat	9	n U.S. 13.	Was Dece If Yes, spe		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	t		American Ind White, etc.	an,
21215-0 d within 72 ho giene. or then "netu		Сотріете	(Spec	15. Decedent cify only highes ondary (0-12)	t grade con	n npleted) College (1-	4or 5+)	(Giv	edent's Usu e kind of wo DO NOT u	rk done d	luring most	t of worki	ing		nd of Busin	ess/Industry	
Maryland 21215-0036 at 2 should be illed within 72 hours att ith and Mental Hygiene "retreamers", or 77 le merked other them "neturel", or recognitions oven the Wedden Event	The same of the sa	lo ge C	17. Father's Name Marvin 19a. Informant's N	Edward	l Shir		on	10h Mai		/24	An	na V	irginia	a Sul	ser	7.01	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. To The Treumed other then "neturel", or Iteme 23a or 28e-1 show my hilivro conher freumatic event. Its Weddest Frampse must be routed		-	David 20a. Method of Dis	E. Ayer	s, Sr	•	tate 20	15 In b. Place of Disp cemetery, cre	dian position (Na	Heigh	nts C	ircl	al Route Numb e Romi Date	ney,	WV 26		
Baltimore, permit. Pages 1 an Department of Heel Important: If item 2	2002		° 4 □ Donation		oecify)	Na	lm	Ebene	Name ar Shaff	nd Addres	s of Facilit	k Fu	neral l	Home	ey, W	TV	
Physici /Medic			23a. Part1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	urt failure. List (Final on	only one ca	NOXI	ch line. C		nter the mod							Interv	eximate al Between t and Death
8760, sate be executed was and mine buriel transit in the buriel transit		EXS	Sequentially list or if any, leading to ir cause. Enter Undicause (Disease or that initiated event resulting in death)	5	b. <u>F</u>	EMPHY Due to (c	SEMA or as a con	sequence of):									
, P.O. Box 687 that the death certificate led by the attending physides continued by the attending physical particles as the	28 000		IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr	? months? □ No	1	Live bir	int at time	etal death 3	□Ectopic p					2	3d. Date of Month	f delivery Day	Year
ecords, P. law requires that as been signed by	3	ò	Part II. D ther signi	ficant conditio	ons contribu	iting to dea	ath but not	resulting in the	underlying o	cause give	en in Part I.		_	/		te to the caus	e of death?
The The gate had a page	000	Completed											24a. Was auto perfe 1 ☐ Yes		24b. Wer prior deat 1 🗆	r to completionth?	dings available n of cause of
Vision of Vita Attending Physicien: r death. ector: After this certification with funeral director.	P P P P P P P P P P P P P P P P P P P	0	25. Was case refe examiner? 1 ☐ Yes 2 ☑ 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	No	Hospi 28	1 W In Ba. Date of		2 ER/Outpatie 28b. Time Injury		28c. Injury Work	er: 4 ☐ Nu	rsing Ho	n (Check only me 5 ☐ Resi 28d. Describe	idence 6		Specify)	
Division ttal or Attending rs efter death. el Director: After de fune	to line	Certification:	3 Suicide 4 Homicide	6 Could r		Be. Place of buildin	of Injury - Ag, etc. (Sp	At home, farm, s ecify)	treet, factor	y, office			28f. Location (City or To			or Rural Route	Number,
DIVI To the Hospital or At within 24 hours effer of To the Funerel Direct completely filled in by	in the leaf of the	ledical	29a. Certifier (Check only one)	2 Medical	Examiner:	n: To the I On the ba and mann	sis of exan	knowledge, dea nination and/or i	nvestigation	i, in my of	oinion, dea	d place, th occurr	and due to the ed at the time,	date and	place, and	due to the ca	
Twith To	3	Σ	29b. Signature and	title of certifier		M	2	1		c. License				29d. Date		fonth, Day, Y	005
5)	;	30. Name and add	renkle	M.D.	600 M	lemora	ail Aver	nue (rland	l, Ma	aryland	2150	02		
Reg	State gistra	e r	31. Date filed (Mor	EB 2 8	3 2005	32. F	gistrar's S	ignature	park	,							

DHMH 17 Rev 1/2001

Registrar

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Certificate of Death	Reg. No.	000	000	1 ()
State of Maryland / Department of Health and Mental	Hygiene	OOE	ACE	10)

Physicia /Medica

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036 Pnysician /Medical Examiner

Helen Bascue

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1	1 - State Registrar	State of Mai			te of Death	nd Mentar	Reg. N	2000	06518
cian	۱	1. Decedent's Name (First, Middle, Last) $Helen K \bullet$	Bascue				2. Date of Month Feb		Day Year 1 2005	3. Time of Death 5:45 AM
lica ine:		4a. Facility Name (If not institution, give si	treet and number)		4b. City	, Town, or Location of			4c. County of Deat	
		Genesis HealthC				Easton			Talb	ot
1		5. Social Security Number 224-28-2290 6. Sex Usual Residence of Decedent	M 2 13xF 7. Age 8	(In yrs. last birthday 3 Yrs.	Months	r 1 Year If Under 2 Days Hours	Min. 8. Date o	f Birth Day 9	1921 co	hplace (State or Foreign untry) VA
	-	10a. State 10b. County		10c. City, Town or I	Location					10d. Inside City Limits
1	5	MD Prince G	Georges	Bowie						1 ¥ Yes 2 □ No
) ire		10e. Street and Number			10f. Zi	p Code		10g. (Citizen of What Co	untry?
0	3	3800 Enfield C				20715			USA	
by Euparal Director	3	11. Marital Status 1 1 1 Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No			edent of Hispanic Orig ecify Cuban, Mexican,	Puerto Rican, etc	r No-	14. Race - Ame Black, White	
		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			No Specify:				hite
Do Completed	2	15. Decedent's Educ (Specify only highest grade	completed)	(Giv	edent's Usu e kind of w DO NOT u	ual Occupation ork done during most use retired)	of working	16b.	Kind of Business/ federal	Industry
1		Elementary/Secondary (0-12)	College (1-4or 5+))	pervi				govt.	
9		17. Father's Name (First, Middle, Last) Ernest Bascue					's Name (First, Mi		en Sumame)	
F	2		0.14	401.14			lith O'I			
	1	19a. Informant's Name/Relationship (Type Terry W. Hebb (s (Street and Number Church				
	İ	20a. Method of Disposition		20b. Place of Disp	position (Na	other place)	Date	20c.	Location - City or	Town, State
		1 ☐ Burial 2分 Cremation 2 ☐ Re 4 ☐ Donation ☐ Other (Specify)	amoval from State	Frederi	ick C	Crematory	2/12/0)5 Fr	cederic	k, MD
	-	21. Signatore of Funeral Service License	(846L	Ī	onai 31 E.	nd Address of Facility Main St	mpson I	uner	al Home	e 21769
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	he death. Do not e					2,111	Approximate Interval Between
	1	Immediate Cause (Final disease or condition	Coma	estive i	Keart	failure				Onset and Death
		resulting in death)	Due to (or a a	consequence of):	1 4 .	/				unat !
	5	Sequentially list conditions, if any, leading to immediate		c sequence of):	aucro					years
i m	LAGIIIIIGI	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	thero	schenosis	gen	undi ad				years
1	Ľ	resulting in death) Last	Due to (or as a	consequence of):	1					
looko	2	d	J							
		IF FEMALE:	3c. If yes, outcome of	f pregnancy					23d. Date of del	iverv
Dhueleleid A	2	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2. 2. No	1 ☐Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ect <i>o</i> pic p				Month	Day Year
hard	133	9 Unknown	9□ Unknown							
1	D.	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying	cause given in Part I.			./	the cause of death?
of projection of	מנים	- Theretone						1 🗌 Yes		obably 4 Unknown
1	1					-		Was an autopsy performed/	prior to o	itopsy findings available completion of cause of
		25. Was case referred to medical				26 Place	of Death (Check of		No 1 ☐ Yes	2□ No
To Do	0	examiner?	lospital:	t 2 ER/Outpati	ent 3□ D				6 □Other (Spe	cify)
		27. Manner of Death D⊠ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	of	28c. Injury at Work?			jury occurred	
	Call	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 h		(2)		
9141		4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, : (Specify)	street, facto	ry, office		on (Street r Town, Sta		ural Route Number,
	medical ceruification,	29a. Certifier Certifying Phys	sician: To the best of her: On the basis of e and manner state	examination and/or	ath occurred	d at the time, date and	f place, and due to h occurred at the t	the cause ime, date a	o(s) and manner as and place, and due	s stated. to the cause(s)
	ME	29b. Signature and title of certifier	70 1	,	29	c. License number		29d. [Date signed (Mont	h, Day, Year)
		> MA	LUMO J			JE59.	35		2.11.05	2
		30. Name and address of person who co	impleted cause of de	ath (Item 23a) (Typ	e, Print)	DANG LA	IL FO	GTM	mn	21631
itat	9	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	1 1111	יוית כחחוי	L NI	J U	7 113	21001
tra		FEB 1 4 2	UU5	can As	March	April 18				

Registrar

			1 - For State Registrar	State of M	laryland		artmen <i>tificate</i>					giene Reg. No.	005	06519
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea	ıth		3. Time of Death
	Physici: /Medic		Patrick S. Bow	ers							Month Februar	cy lay	, 2005	5:30 A M
	Examin		4a. Facility Name (If not institution, give s	treet and number	r)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Dea	th
			746 Valley Rd.					oxvi	.11e			W	ashing	ton
	Funeral		5. Social Security Number 6. Sex		ige (In yrs. la		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Biri	thplace (State or Foreign
	Director		210 30 1703 11	M 2□F	55	Yrs.					May 5,			ryĺand
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	nary:	٥	Washingt	on	,									1 Yes 2X No
	28a-	Director	Maryland Washington 10e. Street and Number			Knoxv	111e	Code				10g Citize	en of What Co	
7	With With	₫	746 Valley Rd.					1758			1	-	ted St	•
	78 2%	Funeral		12. Was Deceden	it Ever in U.S	S. 13. V				gin? (Sp	ecify Yes or No-		4. Race - Ame	
,	riter	Fun	1 Never Married 2 Married	Armed Forces	? JNo 196	- DO				, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	
3	ai', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	100	0	1 ☐ Yes 2	2 1 No	Specify:			3	Specify:	White
	astur cel	Completed	15. Decedent's Educ (Specify only highest grade	cation		16a. Deced	lent's Usua kind of wor			t of work		16b. Kind	d of Business	Industry
, i	9	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	DO NOT us	e retired))	OF WORK	ng	110	0	
7	ygien /gien f, th	Co	12			Mil:	itary					US	Gover	nment
2	d oth	Be	17. Father's Name (First, Middle, Last)								e (First, Middle, Penner		iumame)	
<u>x</u>	Men Men arke	ဥ	Joseph Bowers						17.1.1	ттаг	renner			
2	and is m		19a. Informant's Name/Relationship (Ty)	oe, Print)			-				al Route Numbe	•		Zip Code)
2	and ealth m 27 her ti		Deborah L. Bower	S	001 01			-	D., K		ville, M			
5	t of H it ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from Stat		ace of Dispo metery, cren	sition (Nan natory or o	ne of ther place	e)	ı	Date	20c. Loca	ation - City or	Town, State
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ם י	Depar Depar Impor eny in		21. Signature of Funeral Service License	90	01	1					uffer F			
	au.= a a		(owithey)	Jan	ffe	-		-			lke, Fre		ck ,MD	
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F	hysician		Immediate Cause (Final disease or condition resulting in death)	KING	4DC	ROIN	16	150	New	119				nours
ı	/Medical Examiner		Todaking in deathy	1	s a consequ									. +1
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	545 10 (0										
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9	cale be executed physician and the burial-transit	dical		ı										
0	g phy as the	edlo												
5	Ine law requires that the death certificate has been signed by the attending page 2 should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcom								23	d. Date of del	ivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant			Ectopic pro Other (sp						Month	Day Year
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ecolus,	quire an sig		rancytop	enua							1 □ Y	es 2 🗆	No 3□Pr	obably 4 Unknown
5	s be	Completed	9 .								24a. Was a		24b. Were au	utopsy findings available
	sician: The lay certificate has rector, page 2	mo									autop: perfor	med2	death?	completion of cause of
1 2	an: tifica tor, p	0	25. Was case referred to medical						26. Place	of Death	1 Yes	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2L NO
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2	rs aft rs aft rai Di ed in	Certification:												
	To the frospital or Atlanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the bes	of examinati	wledge, death	occurred a	at the tim	e, date an	d place,	and due to the d	ause(s) a	nd manner as	stated.
	the F the F	Medical	O'lle	and manner	stated.					occurr				
	5 5 6 7 E	2	29b. Signature and title of certifier	HEGA	7.		29c	License	number	161	1 2		signed (Monti	
	X,		M H- 2.	110011	0			Dr	+ 4	101	7	d	- 11 -	
	9		30. Name and address of person who co											
			Zakari Hegazi,			Drive	, Fre	deri	ck, N	1D 2	1702			
	Sta		31. Date filed (Month, Par Year)4 20	05 32 doois	trar's Signat	1 A	ceek	0						

Frances Ann Bauer 05-01028 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 - Stata Registrar Ce	artment of Health and M rtificate of Death	Reg. N	lo.
Physici /Medid Examin	al.	1. Decedent's Name (First, Middle, Last) Frances Ann Bauer 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month February	3. Time of Death 2:53 P M c. County of Death
Funeral Director		1270 Fenwick Garth 5. Social Security Number 213-52-3852 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday 7 Yrs.	Arnold If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Anne Arundel 9. Birthplace (State or Foreign Country) 1947 New Jersey
ath with the Maryland 23a or 28a-f show ust be nutified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Anne Arundel Arnolo			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
72 hours after death with the Maryland natural; or Items 23a or 28a-f show lical Extentine must be recitified at	Funeral Director		10f. Zip Code 21012 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto f		USA 14. Race - American Indian, Black, White, etc.
i within 72 hours after desilene. I inne. I than "natural", or Items Ite Madical Extraline.	Completed by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	1 Yes 2X No Specify: Indent's Usual Occupation It is denity of work done during most of working DO NOT use retired)	ng 16b.	Specify: White Kind of Business/Industry
ba filed tal Hyg nd othe event,	To Be Com			(First, Middle, Maide Budreki	Education an Sumame)
hea m		Valentine R. Bauer/Husband 12 20a. Method of Disposition 20b. Place o	ing Address (Street and Number or Rura 70 Fenwick Garth osition (Name of matory or other place) Februar	Arnold,	or Town, State, Zip Code) MD 21012 Location - City or Town, State
parmit. Pages 1 a Department of Hei Important: If Item any injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature 17 ral Service Licensee	rematory 200 2. Name and Address of Facility arranco & Sons. P. A	A. Severr	altimore, MD na Park Funeral Home
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	95 Gov. Ritchie Hw ter the mode of dying, such as cardiac of Abdowlen and Mul	r respiratory arrest,	Approximate Interval Between
ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): d.			
death certific e attending p	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The law ata has b	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed?	
ing Phy ofter this uneral d	ation: To B	2 Accident investigation 1000 2(05) 2:53	nt 3 DOA Other: 4 Nursing Hom	ne 5 Residence	6 Dother (Specify) at scene ury occurred StabMed & Cut Self
LIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	al Certification:	28e. Place of Injury - At home, farm, st building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the cause(and Number or Aural Aoute Number, te) j 270 FENWICK GOSTV LA, MD (s) and manner as stated.
To the Ho within 24 h To the Fu completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier Hallau Ma	29c. License number OCME	d at the time, date ar	nd place, and due to the cause(s) late signed (Month, Day, Year) ruary 09, 2005
	ite	30. Name and address of person who completed cause of death (Item 23a) (Type CARDLH. ALLAN MA 31. Date filed (Month, Day, Year) 32. Paistrar's Signature.	Print) 111 Penn Street H	Baltimore,	Maryland 21201

			For State Registrar	State of Maryla		oartmer e <i>rtifica</i>			ind Me		giene Reg. No	1 1	0652	
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) A M E S 4a. Facility Name (If not institution, give st	reet and number)	///	BR 4b. Gjiy		UAN Location of)	2. Date of Da Month Februa	Da V	y Year 39 ZCC . County of De	UST 0630.	
	Funeral Director		5. Social Security Number 6. Sex	M 2□ F 71	rs. last birthday Yrs.	y) If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bin Month Da 09/21/	th 1933	9. B	irthplace (State or Fo Country) isconsin	oreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Itams 23e or 28e-f show any highry or other traumatic event, the Midfail Examinar must be notified at ODGs.	To Be Completed by Funeral Director	10a. State 10b. County MARYLAND PRINCE GEO 10e. Street and Number 1303 PARKINGTON LAN	DRGES BO NE 2. Was Decedent Ever in Armed Forces? 1	19b. Mal 130 Place of Discometery, cr.	a. Was Dece If Yes, spe 1 □ Yes Leedent's Use Po kind of we DO NOTE COO illing Addres 3 PARI position (Na erratory or REMAT(22. Name a	all Occupants done a size retired, of Inperat	specify: tition turing most dustr ion 18. Mother VER and Number ON LA a) 2 s of Facility	of working:ial r's Name A HE r or Rural NE Da 2/13/ yROBE	(First, Middle, NSEL Route Number BOWIE, ate 2005	USA 16b. K Depa Maider MD 20c. L WA EVAN	14. Race - An Black, Wr Specify: Wind of Business artment of Sumame) or Town, State, 20716 coation - City of LDORF,	nerican Indian, nite, etc. HITE s/Industry of Defen: Zip Code)	□ No
8760,	death certificate be executed Examine and physician and action (see as the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	ue to (or as a cons	equence of):	hory F		g, such as o		respiratory a	rrest,		Approximate Interval Bathweet Onset and Dead Onset	ath NS
P.O. Box 6	t the by th ache	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 f death 5	B⊟Ectopic p B⊟Other (s	pecify)			222 Bids		23d. Date of d Month	Day Yea	
Vital Records,	The law requires ate has been sign page 2 should be	Completed by	Part II. Other significant conditions cont	ributing to death but not i	esutting in the	underlying	cause give	in in Part I.		1 🗆 ` 24a. Was autop	Yes 3	No 3 1		nown
Division of Vita	Attanding Physician: Thr r death. sctor: After this certificate by the funeral director. pag	ertification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year,		ol / M	28c. Injury Work	at □ Nur	rsing Hom 21	8d. Describe I	dence how inju			
Divi	To the Hospital or Attani within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Certifi	4 Homicide determined 29a. Certifier (Check only 2 Medical Examin	28e. Place of Injury - A building, etc. (Special Control of the best of my left) or: On the basis of example or: On the basis of example or:	cify)	ath occurred	at the tim	e, date and	d place, a	City or Tox	vn, State	a) and manner	Rural Route Number as stated. ue to the cause(s)	
)	To the vithin 2 To the complet	Med	29b. Signature and title of certifier 30. Name and address of person who cou	and manner stated.		10 29	c. License				29d. Da	te signed (Moi	nth, Day, Year)	5
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 0 20	- Kennedy 32. Agistrar Sig	600 A	I. Wo	IFB	St.	BA	Himas	a, 1	Varylan	09 200 H 2128/	3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 9, 2005 A M February 3:01 Normand Henry Bedard, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Yrs Director 028-22-0897 9-2-1930 Massachusetts Usual Residence of Decedent filed within 72 hours after death with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3757 Parke Drive 21037 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 27 No 1 Never Married 20 Married 1 Yes 2/2/No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should ba filed within 7 in and Mental Hygiene. 7 Ie marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Manager Insurance Agency 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simone Fortin Paul Henry Bedard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ant: If item 27 le 1 Jeanne R. Bedard/_Wife 3757 Parke Drive, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: If it eny Injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Kalas Crematory 2-12-05 Edgewater, MD `4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightsee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 wood 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Reporter disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner reunoma WHR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed gestade that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by De Phialler Ronstant Stage 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificata has autopsy performed 1 ☐ Yes Ø No 1 Yes 2 \(\text{No}\) or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funerel Director: After thi
completely fillad in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a McCartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Al-Herbotto D 43371 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Kin 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2001 MEDICAL

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ar's Signature

			1 - For State Registrar	State of M	Maryland / D	epartmen Certificat					iene)5	06523
	Physici	an	Decedent's Name (First, Middle							2. Date of Deat Month	Day	Year	3. Time of Death 2:40 A M
	°/Medic	al	Eve	Mae	Bray	4. 05.	T	1	10 "	rebruar	4 20,	2005	2.70AM
	Examin	er	4a. Facility Name (If not institution, Doctors Communit	•	")		nham	Location of	of Death		4c. County		orge's
	Funeral		5. Social Security Number		Age (In yrs. last birth	day) If Under	1 Year	If Under		8. Date of Birth			lace (State or Foreign
ь	Director		562-16-2582	1 □ M 2√√xF	94 y	months Months	Days	Hours	Min.	8. Date of Birth	916	Nev	/ada
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
	Maryli f sho	ō		e George's		Springs						,	1 ☐ Yes x2√No
	roll	rect	10e. Street and Number	000180 0	, Jan., P	10f. Zip	Code			1	0g. Citizen of	What Coun	
	within 72 hours after death with the Maryland ene. Itan "natural", or Itama 28a or 28e-f show ta Madical Exemirer mant ke notified at	Funeral Director	5609 Lansing	Drive			207	48			USA	A	
	r dea	Iner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Deced	dent of H	ispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)		ce - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3√☐ Widowed 4 ☐ Divorced	ed 1 Tyes 24 If Yes, Give Year or Date:		1 🗆 Yes		Specify:				יי: Whit	
215-0036	tural	ed b	15. Decedent		16a. F	ecedent's Usua	al Occup	ation			16b. Kind of B	usiness/Inc	dustry
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and	be fill ntal H ad ott	Be	17. Father's Name (First, Middle, I	Last)						(First, Middle, M		ne)	
Maryland	should nd Men marke umatic	Ļ O	Samuel Davis 19a. Informant's Name/Relationsh	in (Tyne Print)	19h J	Mailing Address	(Street			Monber		State 7in	Codo
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ē,	f Hea other		20a. Method of Disposition		20b. Place of I						20c. Location		
Baltimore,	Page nent o ant: ff ury or		1 🖾 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp			nd Vet.		ስ'	2/28,	/2005 CI	heltenh	am. M	Maryland
alt	permit. Departr Imports any inju		21. Signature of Puneral Service I	icensee/					y P.	Kalas F	uneral	Home	P.A.
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687	icate physi s the I	Physician/Medical		d.		•		-					
Вох (feath certifica attending ph	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon							23d. Da	te of delive	ry
Ö.	the atte	sicia	in the past 12 months? 1 Yes 2XNo		2 Fetal death at time of death	3 ☐ Ectopic pr 5 ☐ Other (sp					Mo	onth	Day Year
P.0	that the de ed by the detached	Phys	9 Unknown										
je,	ires the signed I be de	by	Part II. Other significant conditio	ns contributing to death	but not resulting in t	he underlying c	ause give	en in Part I.		23e. Did tob	_	tribute to th	e cause of death?
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		a	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes 2 1 (Check only one	1 A	1 🗌 Yes	2 No
Ţ.	00	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🕍 npa	tient 2 ER/Outp	atient 3□ DC)A Dthe			me 5 🗆 Reside		er (Specity)
	ng Pt fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury 28b. Tir Day Year) Inj	ne of 2	8c. Injury Work	at c?		28d. Describe ho			
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Division	in the se	Certification:	4 Homicide determi	ned 288. Place of building,	njury - At home, fam etc. <i>(Specify)</i>	i, street, ractory	, опісе			City or Town	, State)	er or Hural	Houte Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir. completely filled in I	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	of examination and/	death occurred or investigation.	at the tim , in my or	ne, date an pinion, dea	d place, a	and due to the ca ed at the time, da	iuse(s) and mate and place,	anner as sta and due to	ated. the cause(s)
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)	,		> Xm. E	poully		3	000	599	8 6	\	2/2	0/0	5
	6		30. Name and address of person w	who completed cause of			ch	neverly	1 1	nd 2078	35		
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	Registr	ar	FEB 28	2005	see so p							4	

EVE BRAY

State of Maryland / Department of Health and Mental Hygiene) 06524 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ERNEST CLARK BARNHOUSE Year 0506 AM FEBRUARY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day, Year | AUG | 16 | 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 10M 20 F Yrs. 233-66-5394 63 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD WASHINGTON SHARPSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7214 DUSTIN DRIVE 21782 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s filed within 72 hours after de I Hygiene. other then "naturel", or Item 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1969 Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER 8 AGRICULTURE is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental VIRGIL CLARK BARNHOUSE ETHEL MAY LOWE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7214 DUSTIN DR., SHARPSBURG, MD 21782 LINDA BARNHOUSE / SPOUSE Item 27 i Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o cemetery, crematory or other place)
LAYTONSVILLE CEME 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 2/24/05 LAYTONSVILLE, MD ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL
P.O. BOX 86, E 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Du to (or as a consequence of Examiner certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1. Yes 2 □ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No after death | Director: / d in by the fi 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funerel C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 100 npleted cause of death (m 23a) (Type, Print) CAMRI ROAL 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

ORIGINAL

		1 - For State Registrar		epartment of Health and Certificate of Death	Reg. No	2000 06575
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th with th		10e. Street and Number 9501 DYSON R	D.	10f. Zip Code 20613	10g. Ci	itizen of What Country?
after dea		MARYLAND PRINC 10e. Street and Number 9501 DYSON R 11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
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Baltim permit. Pac Depertment Important:	SUCS.	21. Signature of Funeral Service Lice	TIVITIALI	22. Name and Address of Facility RAYMOND FUNERA LA PLATA, MARY	L SERVICE,	
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ecords, P.O. law requires that the das been signed by the	1	Part II. Other significant conditions (contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
The lay ate has		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
00		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ath (Check only one) Home 5 Residence	6 ☐Other (Specify)
After Find		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio		e of 28c. Injury at	28d. Describe how inju	
- 595			building, etc. (Specify)		City or Town, State	
To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier 122 Certifying Pt (Check only 2 Medicel Examone)	nysician: To the best of my knowledge, d niner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the cause(s urred at the time, date and) and manner as stated. d place, and due to the cause(s)
To th Within To th		29b. Signature and title of cartifier	May MD	29c. License number D 00 52	200 2	te signed (Month, Day, Year)
6		30. Name in laddress of person who ALL RAHIMLA	completed cause of death (Item 23a) (Ty	POB. Print) SURRATTS RO	AD 205 (LINTON MD 26730
Red	State	31. Date filed (Month, Day, Year)	32. Agistrar's Signature	Corolis		LINTON MD 26735

State of Maryland / Department of Health and Mental Hygiene-06526 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 6, 2005 **Physician** Year RUTH J. CHANDLER 11:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GLADE VALLEY NURSING HOME WALKERSVILLE FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, MARCH 5, 9. Birthplace (State or Foreign Funeral Days Hours 1 ☐ M 2 💢 F Min WASHINGTON, DC 90 578-34-1710 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "natural", or iteme 23a or 28a-f show the Medical Examinar must be nutified at WALKERSVILLE 1 Yes 2 No FREDERICK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 W. FREDERICK STREET 21793 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THEATER OWNER/OPERATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Pages 1 and 2 should be ARTHUR DAVIS BYRD MINNIE LEE McARTHUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 ie
any injury or other trau LINDA ECKERT/DAUGHTER 431 JEFFERSON AVE., CHARLES TOWN, WV 25414 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEBRUARY X Burial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV ROSEDALE CEMETERY 9, 2005 *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee XAL HÖMEY P.O. BOX 821, MARTINSBURG, WV 25402, 327 W. KING ST., fraeles W Oun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Therosclero To 24655 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.G. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached i 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SAMO 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed this certificate 1 Tyes HVo funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 varsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After of to. √s after deau. ¬⊶l Director; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0031058 02-09-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10200 Coppermine Rd, PO Box 6, Woodsboro, MD 21798 Gene F. Ashe, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 16 Registrar

05-01077 B.K.S DELORES S. CARTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(OK.)	ES S. C	ARI	IER For State Registrar	State of Maryland		artment of Hertificate of L			ene 005	06527
	0		Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
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	and and	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
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9	be filed within 72 hours after death with the Maryland lal Hygiene. Id other than "natural", or Items 23a or 28e-f show other than "natural", or Items 23a or 28e-f show event, I'm Medical Eventing minist be recilified at	Funeral	11. Marital Status 1 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes XXNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	e, etc.
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nor	of T		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State FO		natory or other place INCOLN			RENTWOOL	
Baltimore,	permit. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service License) 22	2. Name and Addres	s of Facility REE	SE PROF	TESSIONAI	F.S.
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n of	ng Ph Iter th Ineral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time o	Work		28d. Describe how	v injury occurred	NS-08-2011311
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (ician: To the best of my know er: On the basis of examination and manner stated.						
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U				thall, MD			nn Street	Baltimo	ore, Maryla	and 21201
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			For State Registrar	State of	f Maryland /	Depa	artment artificate	t of He	ealth and I	Mental Hy	giene Reg. No.	2005	065	528
			Decedent's Name (First, Middle, L.	.ast)	***					2. Date of Dea	ath	V	3. Time of	Death
	Physici /Medio		Anne Cohen							Februar	у 4 ,	2005 Year	4:15	РМ
	Examir		4a. Facility Name (If not institution, g	ive street and nur	nber)		4b. City,	Town, or L	ocation of Deatl	n	4c.	County of Death	1	
			Millennium Healt	h of Bel	Pre		Silv	er S	pring		Mo	ntgomer	У	
	Funeral		, , , , , , , , , , , , , , , , , , , ,		7. Age (In yrs. last		If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 11,	h v, Year)	9. Birth	place (State of intry), andria,	r Foreign
	Director		578-05-2599	1□ M 2\ F	87	Yrs.				May 11,	191	7 Alex	andria,	, VA
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Lo	cation						10d. Inside Ci	ity Limits
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	28e-	ect	MD Montgom 10e. Street and Number	ету	211/	/e1 3	pring 10f. Zip				10a. Citiz	zen of What Cor		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show importent: If item 27 is marked other then "naturel", or items 23a or 28e-f show any injuy or other treumstic event, the Medical Exacting must be rediffed at once.	Completed by Funeral Director	2601 Bel Pre Roa	d				20901	l			ted Sta		
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Baltimore,	T is in		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	☐Removal from	State 20b. Place ceme	e of Dispo etery, crer	sition (Nan natory or o	ne of ther place,)	Date	20c. Lo	cation - City or 1	Town, State	
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alt	epart sport sport ny inj		21. Signature of Funeral Service Lic	ересе	۰.00	22	2. Name an	d Address	of Facility Hi	nes-Rina	ldi	Funeral	Home,	Inc.
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760,	Physician / Medical Examiner e prijarijarijarijarijarijarijarijarijarija	cai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate caus. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last	conves Due to (corona b. Due to (hyper	stive hear (or as a consequent ry artery (or as a consequent tension (or as a consequent	ce of): 7 dis							Interval Bat Onset and I	ween
P.O. Box 687	death certifica e attending ph of for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, out	tcome of pregnancy pirth 2 ☐ Fetal de nant at time of death own	ath 3□	Ectopic pro				2	23d. Date of deli-		Year
	requires that the een signed by th nould be detache	by F	Part II. Other significant conditions					ause giver	n in Part I.	23e. Did to	obacco u	se contribute to	the cause of d	leath?
Vital Records,	w require been si should I	ed	Chronic obstr	uctive p	ulmonary	dise	ase			1 🗆 1	/es 2[□No 3□Pro	bably 4 🛣	Jnknown
000	e law re has be	Completed	pace-maker							24a. Was		24b. Were aut	opsy findings ompletion of c	
ž	0 - 0	E	preperal vasc	1			_			perfo	rmed? 21⁄2 No	death?	2 ∏ No	ause 01
ta	sicien: Th certificate rector, pag	a	25. Was case referred to medical	urar dis	ease				26. Place of Dea	ath (Check only o				
\ 	O S	To B	examiner? 1 □ Yes 2🌠 No	Hospital: 1 □ I	Inpatient 2 ☐ EFV	Outpatier	nt 3□ DO	Other	4 X Nursing H	lome 5 🗆 Resid	dence 6	6 □Other (Spec	ity)	
u of			27. Manner of Death 1 XNatural 5 Pending	28a. Date (Mon	of Injury 28 th, Day Year)	b. Time o	f 2	8c. Injury	at	28d. Describe h	ow injury	occurred		
Division	Attending r death. sctor: After y the fune	Certification;	2 ☐ Accident investigat				М	1 🗆 Y	es 2 No					
Ĭ Ži§	r Att	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	200. Flace	of Injury - At home ing, etc. (Specify)	, farm, str	eet, factory	, office		28f. Location (S City or Tox	Street and	d Number or Ru	ral Route Num	ıber,
	itet o rs aft el Di	Cer												
	To the Hospitet or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	aminer: On the b	a best of my knowled asis of examination ner stated.	dge, deat and/or in	h occurred vestigation,	at the time in my opi	e, date and place nion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	;)
	To t To t	Σ	29b. Signature and title of certifier	2			290	. License				e signed (Month		
	21		▶ Bwww					0	51520		Febr	cuary 8,	2005	
	V		30. Name and address of person when Bahram Pishda	d, MD 98	se of death (Item 23 01 Georgi	a) (Type, a Av	e. Si	lver	Spring,	MD 2090)2			
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 10	2005	egistrar's Signature	A	ale	,						-

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

Physician

/Medical

Examiner **Funeral** Director Funeral Director 5 ò 3altimore, Maryland 21215-0020 ۵ Be Completed end Mental Hygiene. s marked other than Pages 1 and 2 should be nant of Heelth end Mental If Item 27 Depertment of important: if its any injury or o Physician /Medical Examiner Physician/Medical Examiner ۾ Completed Be Medical Certification: To Director: To the Hospital within 24 hours a To the Funeral C 40055845 end eddress of person who completed cause of death (Item 23a) (Type, Print) **KEVIN** BREWSTER D.O. 688C POOLE ROAD, WESTMINSTER, MD 21157 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

		ŀ	1 - For State Registrar	State of Mai		artment of H rtificate of L			jiene eg. No.	05	065	30
		Ш	Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of	Death
	Physici /Medic		Ellen Purner Cantl	er				Month Februar	Day	Year 2005	9:45	\mathbf{p}^{M}
	Examin	_	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death			nty of Death		
		2	111 West Walnut St			North Ea			Ceci			
	uneral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday) On Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Cour		r Foreign
_	irector		Usual Residence of Decedent	21	82 Yrs.			Dec. 5,	1922	Mary.	Land	
land	MOI		10a. State 10b. County	-	10c. City, Town or Le	ocation				1	0d. Inside Cit	y Limits
Маг	P P P	ţċ	Maryland Cecil	-	North Eas	t					1 X Yes	2 🗌 No
th the	or 284 e not	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen	of What Cour	ntry?	
ith wi	23a Ust D		111 West Walnut St	reet		21901		1	United	State	es	
ar dea	tems	Funerai	11. Waltar States	Was Decedent Ev Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spanic American, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,		
s afte	o l	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Spe	city: Whit	e	
be filed within 72 hours after death with the Maryland	nd anygiene. dother than "natural", or items 23a or 28a-1 show event, itte Medical Examinations be notified at	edt	15. Decedent's Educ		16a, Dece	dent's Usual Occupa	ation		16b. Kind of	Business/Inc	dustry	
7 rin 7	Ned in	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	lurina most of work.	ing			,	
d with	or tha	E O	11	College (1-40) 3+,		al Assist	ant		Educat	ion		
	s other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name					
should b	and mental hygiene. Is marked other than aumatic event, the M.	٦ ا	Marshall Purner				Martha M	eekins				
2 sho	fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Number	r, City or Tov	vn, State, Zip	Code)	
1 and	m 27 her ti	1 3	George Cantler, Jr 20a Method of Disposition	./Son	176 (Greenbank	Road Per	ryville				
seg	Important: If ite any Injury or ot once.		1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cre	osition (Name of matory or other place ost Method: emetery	e) ist Febru	arv 16	20c. Locatio	n - City or To	wn, State	
r Pa	rtant		*4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Spryice License	2	C	emetery	20	05	North	East,	iarylar	nd
perm perm	Important land land land land land land land land		21, Signature of Publical Service Clears	9		2. Name and Addres						
600			23a. Part1. Enter the disease, or complic	ations that caused the		27 South 1				,Maryl	and 21	
Di-			shock, or heart failure. List only one	e cause on each line				, , , , , , , , , , , , , , , , , , , ,	,		Interval Betw Onset and D	veen Jeath
	/sician ledical		disease or condition resulting in death)		consequence of):	ast Cav	w				YEARS	
Exa	aminer			•	oonsoquonee org.							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):							
cuted	nd transi	Examiner	that initiated events									
cate be executed	physician and is the burial-transit		resulting in death) Last	Due to (or as a	consequence of);							
catet	physic the b	dicai	d.									
The law requires that the death certification	ed by the attending p detached for use as	0	IF FEMALE: 23	c. If yes, outcome of	pregnancy				024	Date of delive		
eath C	atter for u	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at til	Fetal death 3	Ectopic pregnancy Other (specify)				Month	*	'ear
the c	y the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
s that	igned b	by PI	Part II. Other significant conditions conf	ributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use co	ontribute to th	e cause of de	∍ath?
daire	07 75		CHRONIC OBSTRUCTI	ve pun	UNANY DISE	MSE		1 □ Y€	es 2 No	3 ☐ Prob	ably 4 □U	nknown
aw re	has been je 2 shouk	plet	HYPERLIPIDEMIN					24a. Was a autops			psy findings a	
The	ate	Completed	NON INSULIN DEP	FURALA DIA	BETES ME	LLITUS		perform	ned?	death?	_	.030 01
cian:	director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only on	e)			
hysi	this c	ို	1 163 2 100		2 ER/Outpatie	-	4 Nursing Ho	me 5 Reside			1)	
ding i	After th funeral	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	at ?? /es 2 □ No	28d. Describe ho	w injury occ	eurred		
itten (ctor: y the	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury	/ - At home, farm, str		-	28f. Location (St.	reet and Nu	mber or Rura	l Route Numb	per
lor	Direct Direct J in by	erti	4 Homicide determined	building, etc.	(Specify)	cot, ladory, office		City or Towr	n, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	71.00107.01110	,0.,
To the Hospital or Attending Physician:	To the Funeral Directors and Completely filled in	edical C	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin	ician: To the best of er: On the basis of e	my knowledge, deat	h occurred at the tim	e, date and place,	and due to the ca	ause(s) and	manner as st	ated.	
the	the I	Med	one) 29b. Signature and title of certifier	and manner state	od.	29c. License				ned (Month,		
To	8 7 8		Signature and title of certifier				47 7 11		-		5,2003	5
	,	1	30. Name and address of person who cor	nnleted cause of doa	th (Itam 23a) /Tues	70-20			1-510	7	-,	
	0			1-306 Nor		11 -	ELHTON !	u ARYLAN	0 219	اد		
	Sta	ite	31. Date filed (Month, Day, Year)		s Signature							
	Registr		FEB 1 5 2005	Kind !	A GOOD	· •						

			1 - For State of Mai		artment of ertificate of			giene 00 E	06531
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Emma Mary Carroll A. Facility Name (If not institution, give street and number) Allegany County Nursin	g Cente:		or Location of Deat		9 2005 4c. County of D	5:30A M
	Funeral Director		5. Social Security Number 242-18-0599 Usual Residence of Decedent	(In yrs. last birthday) 95 Yrs.	Months Days		(Month, Da	th y, _{Year)} 9. 16,1909 No	Birthplace (State or Foreign Country) Orth Carolin
	the Maryland 28e-f show	rector		10c. City, Town or Li				10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Country?
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "naturel", or items 23e or 28e-f show event, the Madical Examinar must be mailfied at	by Funeral Directo	9 Asbury Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 1 Yes 2 No If Yes, Give		2150	Hispanic Origin? (S ban, Mexican, Puerl		USA	xmerican Indian, /hite, etc. `White
21215-0036	filed within 72 hou Hygiene. Ather then "nature ont, the Modical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) 4	(Give	edent's Usual Occu e kind of work done DO NOT use retin	nager		16b. Kind of Busine	
Maryland	od be	To Be	17. Father's Name (First, Middle, Last) Leroy Waters 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Stree	Kathe	erine U	Maiden Sumame) nknown er, City or Town, Stat	e, Zip Code)
Baltimore, M	Pages 1 and 2 shouk nent of Health and Me sut: If item 27 Is mark iry or other treumatic		William Carroll-Husband 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cometery, cre Rocky Ga	_	ve, LaVa	Date 2005	21502 20c. Location - City Flintsto	
Baltil	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease of complications that ceused to) 2 H	2. Name and Addr Hafer Fu	ress of Facility	ervice	, PA	
8/60,	law requires that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit	dicai Examiner	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a condition).		TRIV2	ing, such as cardiat	or respiratory an		Interval Between Onset and Death ONE YR
O. Box 6	at the death certifica by the attending ph tached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	⊒Ectopic pregnand □ Other (specify)	су		23d. Date of Month	delivery Day Year
Vital Records, P	9 4 9	Completed by PI	Part II. Other significent conditions contributing to death but SEVERE OSTEO PORES HISTORY OF ETHERO			iven in Part I.	1 ☐ Y	an 24b. Were prior med?	
Ö	ding Physicien: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	28b. Time o	of 28c. Inju	ther: 4 Nursing H	ome 5 ☐ Resid	2.2 No 1 None) dence 6 Other (Some injury occurred)	
Division	At at at	al Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc.				City or Tow	vn, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dii completely filled in	Medical	(Check only 2 Medical Exeminer: On the basis of e and manner state	xamination and/or in	29c. Licen	opinion, death occurse number	rred at the time, o	29d. Date signed (Mo	onth, Day, Year)
	Sta Registr	te ar	30. Name and address of person who completed cause of dea Dr. Robustiano Barrera, N. 31. Date filed (Month, Day, Year) FFR 2 8 7005	ith (Item 25a) (Type,		Cumberl	and MD	Feb 21, 21502	2003

DHMH 17 Rev 1/2001

July 2010 may 12 may 12 mag

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jennie **Physician** Margaret Clingan February 2005 1915 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Carroll County Lorien Taneytown Taneytown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 💢 F 91 Yrs. 216-78-8343 23 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at Maryland Carroll County 1 ☐ Yes 2 📉 No Keymar Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6942 Middleburg Road 21757 United States filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white ģ 3 X Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F Is marked of Caleb N. Wolfe Fannie Winfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other traum once. E. Raymond Clingan / 6942 Middleburg Road son Keymar, Maryland 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 24 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Lutheran Cem. Taneytown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service License 136 East Baltimore Street Taneytown, Md. 21787 Turns Man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy ANOREXIA 2**X** No 1 Yes To the Hospitel or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054580 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 417 East Baltimore Street Taneytown, Maryland 21787 Wasim Fakhar, M.D. Registrar's Signature 31. Date filed (FOETB Dag Y81) 2005 State Registrar

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	Physici	an		e (First, Middle, Las					2. Date of Deat Month	Day V	3. Time of Death
	/Medic	tal.	Patric			xon	4h Cihi Taura an	Lecation of Dooth	Februa	1 1	005 2:50 P M
	Examin	ıer		lf not institution, give Maryland		,	Clinton	Location of Death		4c. County of	George's
-	5		5. Social Security N			ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		
9	Funeral Director		214-76-	4	□M 2 X F	45 Yrs.	Months Days	Hours Min.	(Month, Day, May 26	, 1959	Birthplace (State or Foreign Country) Md.
\cap			Usuel Residence o								
	show	_	10a. State	10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 □ No
	the Ma 28a-f	ecto	Md. 10e. Street and Nu	P.G.		Hillcre	st Heig	hts	1	0g. Citizen of Wha	
	iter death with the Maryla r Items 23a or 28a-f shov in er nout be notified at	Funeral Director		artis Dr	ive #101	1	207	46	1	United	•
	ter death Items 2:	era	11. Marital Status		12. Was Deceden		Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-		American Indian,
21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Items 23a or 28a-f show unatic event, if a Modical Examination and the notified at	þ	1 Never Marr Widowed	ried 2☐ Married 4☐XDivorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Š No	1 Tes, specify Cubar 1 ☐ Yes 2 🖾 No	Specify:	rican, etc.)		White, etc. Black
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121	within	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	<i>DO NOT u</i> se retired, eteria W			Private	6
	Hygie Hygie ther t		12 17. Father's Name	(First, Middle, Last)		Care	scella w	18. Mother's Name	(First, Middle, I		
au	ld be ental ked o	To Be	James	H. Robi	nson			Mary L.	Ducket	tt	
Maryland	shound Minari	1		ame/Relationship (7		19b. Maili	ng Address (Street a	and Number or Rura	I Route Number	; City or Town, Sta	ate, Zip Code)
	and 2 ealth a n 27 ls		Mary L	. White/	mother	680 For	l Bock R Washin	gton, M	d. 207	4 4	
ore	of He of He fiter		20a. Method of Dis	position Cremation 3	Removal from State	20b. Place of Dispo				20c. Location - Cit	y or Town, State
<u>ä</u>	Pages ment of I ant: If its ury or o			5 Other (Specify		Ft. Line				Brentwo	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, II a M ODGs.		21. Signature of Fu	uneral Service Licen	S99		2. Name and Addres				
	005 4 0		4210	ue Ele	wind	d the death. Do not entline.					d, Md. 20746
	Physician and /Medical Examiner step physician and physician and physician and physician step ph	l Examiner	Immediate Cause disease or condition resulting in death) Sequentially list confirm any, leading to incause. Enter Unde Cause (Disease or that initiated event resulting in death)	(Final on ditions, mmediate arriving s	Subaracla artery and Due to (or a Due to (or a c.	hnoid hemor	rhage ass	ociated w	ith rup	tured cer	Interval Between rebrate and Death
68760,	cate b physic	dical			d						
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 ☑ Unknown	? months? □ No		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	•
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000	aw requir as been si 2 should I	Completed							24a. Was a autops	n 24b. Wer	re autopsy findings available r to completion of cause of
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ita	ician: Th certificate ector, pag	Be C	25. Was case refe examiner?	rred to medical				26. Place of Death			
>	hysic his ce I dire	To	1 🔀 Yes 2 🗆		Hospital: 1 ☐ Inpat			4 Nursing nor		ence 6 Other ((Specify)
u	iding Physicia Ih. : After this cert funeral direct	lon:	27. Manner of Dea 1 ▼ Natural	5 Pending	28a. Date of In (Month, D	ay Year) 28b. Time o	Work		28d. Describe ho	ow injury occurred	
Division	or Attendi fter death. Director: A in by the fu	ertification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place of Ir	njury - At home, farm, str stc. (Specify)		Yes 2 □No	28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical Ce	29a. Certifier (Check only one)			t of my knowledge, deat of examination and/or in stated.					
	othe omple	Me	29b. Signature and	title of certifier			29c. License	number	2	9d. Date signed (A	Month, Day, Year)
	- > - 0		1/1	when Il	King		0.C.	M.E.	F	ebruary	16, 2005
0			30. Name and add			death (Item 23a) (Type,		-			,
K-				DORE MI			111 Pen	m Street,	, Baltim	ore, Mar	yland 21201
*2	Sta		31. Date filed (Mor		32. Regis	trar's Signature					
Div	Regist	25 6	ret	3 2 3 2005	plan	1 1911					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:05 A 11,2005 February Douville Terry Arthur /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 25, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 12 M 2□F Yrs. 1953 Maryland 215-52-7797 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Extendior must be notified at 1 X Yes 2 ☐ No Directo Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 990 Waterford Drive 21702 Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be and Mental I Anne Koerber Arthur Alfred Douville 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health Barbara A. Frazier - Sister 3046 Kin, James Drive, Dayton, Ohio other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If It any injury or o once. 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematorium 2/13/05 Alexandria, Virginia . Name and Address of Facility 21. Signature of Funeral Service Licensee Olin L. Molesworth P.A., Funeral Home 20272 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lweek Physician PHONONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) as the burial-Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MUSCULAR DYSTROPHY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABLIES perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death | Director: / d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 To the 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of continer n 32171 12/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21793 L. GOUGH WALKORSU, LLE and RICHARD PU BOX 328 31. Date filed (Month Day B'ear) 4 32. R Sistrar's Signature 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiefie 0 5 35

		Ĺ	1 - State Registrar Amended #20b	as per FH; FCHD	Certificate of Death TI	M02/14/200	\$6.	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	SCHEL			ay Year	3. Time of Death - 1:22 P. M
	/Medic	al	4a. Fecility Name (If not institution, give si		4b. City, Town, or Location of Death	FED.	9 2005 4c. County of Deet	<u> </u>
	Examin	er	BEVERLY HEAD	TH CARE	FREDERICK		FREDER	
	Funeral Director		466-14-6667	M 2□F 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year DEC (C)	ar) Co	nplece (State or Foreign untry) YORK MY
	land ow		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		**	10d. Inside City Limits
	a-f sh	ito	MO. FREDER	ick FI	REDERICK			1 ☐Yes 2 ☐ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 155 WILLOW d	ALE DR.	10f. Zip Code 21701	10g.	Cilizen of Whal Co	untry?
200	be filed within 72 hours after death with the Maryland Hygiene. Hygiene, of cher than "netural", or Items 23s or 28s-f show event, the Madical Examinar must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes. 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto □ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify:	
5	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/	Industry
7	within 7	Completed	Elementary/Secondary (0-12)		(Give kind of work done during most of won life. DO NOT use retired) I TERNATION ECON		NEPT, C	F LABOR
7	filed v Hygie other t		17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid		IF LIBUR
<u> </u>	uld be Mental irked o	To Be	ISAdORE DI	SchEL	Rose	ROSENI		
Mar	permit. Pages 1 and 2 should be Depertment of Health and Menta Important; If item 27 is marked sny injury or other traumatic e ones.		19a. Informant's Name/Relationship (Typ) FRANK ÚISCHE	1	Mailing Address (Street and Number or Ru 176 DAVID LAWE	ral Route Number, Cit FAEDER I	/	4 4 4 4 6
บ์ วั	es 1 a of Hes of Hes if item ir othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	20b. Place of cemetery	Disposition (Name of		Location - City or	Town, Stete
Dallillor	t. Pag tment tant: I		* 4 □Donation 5 □ Other (Specify)	FI Remi	Thisburg Crematory		NITHSBUR	
מ	Depermit Depermit Import sny irr 2002		21. Signature of Funeral Service License	lun	10 w. South St.	FRED. P	INS FULL	CRAINCHE 01
			shock, or heart failure. List only on	cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pue to (or as a consequence o	TO THRIVE			
	Examiner		Conventially list annellings	CENEBBAL	VASCULAR A	ccinen.	Т.	
	pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	f):			
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00/00	ysicier		€ d.					
00	ertificate be ling physicie e as the bur	Medical	IF FEMALE:					
J. DO	The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physiclan/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
ŗ	that the		Part II. Other significant conditions cont	inbuting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute lo	the cause of death?
Records,	equires en sign	ed by				1 🗆 Yes		/
သ	law re las bee	Completed				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ב ה	r The					performed	death?	2 No
VIII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Ospital: 1 ☐ Inpatient 2 ☐ ER/Out		th (Check only one) ome 5 Residence	€ □Other (Stee	26.1
0	ng Phys ter this neral dii	n: T	27. Manper of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Ti		28d. Describe how in		ary)
UNISION	tendir leath. tor: Al the fu	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
2	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate had completely filled in by the funeral director, page	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, elc. (Specify)		28f. Location (Street City or Town, St.	ate)	
	ne Hospi n 24 hou ne Funer bletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicat Examin	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occur	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	¥	29b. Signature and title of certifier		29c. License number		Date signed (Month	
	0		P JIM 1	M. M	D 00 4795		-11-2	
	9		30. Name and address of person who con			FREDERIC	K, MD	21701.
			31 Date filed (Month, Pay, Year) 4 2	32. Resistrar's Signature			•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Helen. King Duva11 February 9:21 P M 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 89 Yrs. 6. Sex Birthplace (State or Foreign Country) 1 □ M 2 X F March 31, 1915 Maryland 214-18-2765 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16616 Alden Avenue 20877 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ♥ No Specify: Specify: 3 □XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Atomic Energy Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Deets King Macie Schaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garner W. Duvall, Jr. - Son 9813 Watts Branch Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 2 Cremation 3 Removal from State S ☐ Other (Specify) Parklawn Memorial Park Feb. 14, 2005 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home Kovert & 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PERITON IT IS 2 111 Due to (or as a consequence of): DIUERTICULAR 20115 ABSCESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ASTHMA 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☑ No 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed burial-t Division of Vital Records, P.O. Box 68760, attending physician as the After this within 24 hours are. Control to the Funeral Director: /

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinational be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

023630

3

31. Date filed (Month Day Year) 4 2005 Registrar

29b. Signature and title of certifier

FRANK J. MATOMA

32. Paristrar's Signature

war.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 FREDERICK RO #213, GASTHERIBURL. MO

29d. Date signed (Month, Day, Year)

FEBRUARY 9. 2005

		4	1 - For Amend Item	State of Market Dr.	arylar G84	3,05 <i>E</i> 2	artme 1059 tiflca	nt of H hb <i>te of L</i>	ealth a Death	ind Me	ntal Hy	giene Reg. No.	005	5 (0653	3 7
	Physici		1. Decedent's Name (First, Middle, Las Robert Les	•	e	Ev	ans	III		1	nate of Dea Month Sebruar	ath Day	/ Ye		3. Time of Do	M
	/Medic Examin		4a. Facility Name (If not institution, give Frederick Memo		oital		4b. City	, Town, or Frede	Location o				County of C	Death		
	Funeral Director		214-34-0291	ex 7. Ag	e (In yrs. 68	last birthday) Yrs.	If Under	Days	If Under 2 Hours	Min.	Date of Birt (Month, Day July 2	y, Year)		Birthpla Countr	ice (State or F y) Land	Foreign
	show ed at	'n	Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo								100	d. Inside City	
	with the M a or 28e-f be notifie	Director	W.Va. Berkele			Martin	_	p Code					izen of Wha	t Countr		
036	d within 72 hours after death with the Maryland jiene. I than "natural", or items 23a or 28e-f show the Medical Evanamer must be netflied at	by Funeral	100 S. Queen Stre 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	No		Was Deci If Yes, sp 1 Yes	ecify Cubai		gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		S.A. 14. Race - A Black, V Specify:		tc.	
Maryland 21215-0036	within lene. than	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12		5+)	life.	kind of w	ork done d use retired,	uring most	of working			ind of Busin	ess/Indu		r
yland ;	d is b	To Be C	17. Father's Name (First, Middle, Last) Robert Leslie Ste	ele Evans	, Jr	•			Cat	herin	First, Middle, e Eliz	Maiden abei	Sumame) th Fri	end		
	ealth and 27 I		19a. Informant's Name/Relationship (Jim Evans - Son	Type, Print)	20h	1075-	-E Si	erma	n Ave	nue	Route Numbe	town	a, Md.	21	740	
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	y)	H	Place of Dispo cemetery, crer agersto	own (Crema	$tory^1$	ebrua 2, 20	05	Hay	cation - City	wn,	m, State Mary 1:	and
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Licer		4 86		415 E	. Wi	lson :	Blvd.	nich F Hage	rsto		ld. 2	21740	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li a. Arteri	oscl	erotic						rest,		li C	Approximate nterval Betwe Driset and Dea Years	en ath
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	b. Due to (or as c. Due to (or as	a consec	queпсе of):										
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	aldeath 3	Ectopic p Other (s	pregnancy					23d. Date of Month		r lay Yes	ar
0	quires that t n signed by uld be deta	þ	Part II. Other significant conditions of	ontributing to death b	ut not res	sulting in the u	nderlying	cause give	n in Part I.			bacco u		e to the	cause of dea	
Records,		Completed									24a. Was autop perfor 1 Yes	sy	deat	autops to comp h? Yes 2	sy findings ava pletion of caus	ailable se of
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on	Attending Phy r death. ector: After thi by the funeral o	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	irv	28b. Time of Injury		28c. Injury Work	at	28	d. Describe h			poony		
Divis	i Diff o	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At h c. (Speci	ome, farm, str	eet, facto	ry, office		28	Location (S City or Tow			r Rural f	Route Number	r.
	the Hospitel in 24 hours a sine Funarel in pletely filled	edical	(Check only 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examina	owledge, death ation and/or inv	vestigatio	n, in my op	inion, deat	d place, and h occurred	d due to the d at the time, d	ause(s) date and	and manne place, and	r as stat due to th	ed. he cause(s)	
)	To the vithin 2 To the complet	Z	29b. Signature and title of certifier	U		~	29	D351					e signed <i>(M</i> ruary			
<i>اک</i>	1-5+1		30. Name and address of person who Andrew Zarick,			n 23a) (Type, est Sev		Stre	eet, l	Frede	rick,	mary	land	2170	01-4501	1
	Sta Registi	_	31. Date filed (Montr. Par. Year) 2	OO DESCRIPTION	ada Cian											

			For State Registrar	State of Marylar		artment of H rtificate of L			giene Reg. No.	05	06538
	Dharaiai		1. Decedent's Name (First, Middle, Last)				-	2. Date of De Month	Day	Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or		ith		ty of Death	
			12521 Palermo Dri 5 Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	Spring	s. 8. Date of Bir		tgomer	olace (State or Foreign
	Funeral Director		577-18 - 4587	M 240 F 8	V	Months Days	Hours Min		av. Year)	Cour	Ohio
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Aaryk I sho	ь			Cileon	Comina					1 ☐ Yes 2 ☐XNo
	28e-	Director	Maryland Mont 10e. Street and Number	gomery	pirver	Spring 10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3e or	<u>-</u>	12521 Palermo Dr	ive		20904	4		US	SA	
21215-0036	d within 72 hours after death with the Maryland giene. or than "natural", or items 23e or 28e-f show the Maccal Examiner must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Speci	ack, White, ify: Bla	etc.
Ö	2 ho	ted	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual Occupa	ation	orkina	16b. Kind of E	3usiness/Ind	dustry
215	within 7 ene. than "r	ompieted	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	Home	
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Maryland	m - 0 %	Be	Floyd Holbert					7a Rush	, Walden Suma	mej	
Ž	2 should be f and Mental H is marked of raumatic eve	2	19a. Informant's Name/Relationship (Type	ee, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or Town	ı, State, Zip	Code)
Ma	nd 2 s Ith an 27 is r trau		Howard L. Erwin/			21 Palermo					
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked eny injury or other traumatic evonce.		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crer	esition (Name of matory or other plac	!	ruary 11	20c. Location		
ţ	t. Pag rtmen rtent:		'4 □Donation 5 □ Other (Specify)			morial Cemet		2005	Suitlar	-	ryland
Bal	Depared Important Importan		21. Signature of Funeral Service License	Lole	Fr 50	2. Name and Address rancis J. 00 Univers	"Collins sity Blv	Funeral	Home :	[nc. Sprinc	g, MD 20901
	Pnysician-	W I	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the dea e cause on each line. Metastatic					rrest,		Approximate Interval Between Onset and Death Weeks
	/Medical		resulting in death)	Due to (or as a conse							
	Examiner		Sequentially list conditions, b	Bus to former							— JUNE SERVE
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a conse	quence or):						
•	icate be executed physician and s the burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):						
58760,	siclan buria	alE									
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D. Box	at the death certifica by the attending phached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
P.O	that the ned by the detache		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
Records,	90 90	d by	Bladder Cancer	•		, ,		1 🗆	Yes 2 No	3 Prob	ably 4 Unknown
20	w requir been si should	ompieted						24a. Was	an 24b.	Were auto	psy findings available
Rec	9 2 9	d m						auto	psy ormed?	prior to cor death?	mpletion of cause of
Vital	ificate or, pag	o C	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only o		1 🗆 Yes	2 NO
5	Physicien: this certific ral director,	0.0	examiner?	ospital: 1 Inpatient 2] ER/Outpatier	nt 3 DOA Othe		Home 5X Resi		her (Specify	Y)
J Of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		/ at		how injury occu		
ior	Attending Ir death. ector: After by the funer	atic	1 XXatural 5 ☐ Pending 2 ☐ Accident investigation			M 1 🗆 '	Yes 2 □ No				
Division	or Attendation of the or after deat Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, str ify)	eet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	I Route Number,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in E	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kn ter: On the basis of examin and manner stated.	owiedge, death ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and m date and place	ianner as st , and due to	tated. the cause(s)
	o the ithin (o the omple	Mec	29b. Signature and title of certifier) O	1	29c. License	number		29d. Date sign	ed (Month,	Day, Year)
	7_		1 Marial	1412 HAR	mis	MM D	29923		Februa	ary 9,	2005
		3	30. Name and address of person who co	mpleted cause of death (Ite	m 234) (Type,	Print)				77	
			Marie A. Dobyns,		Van Dus	sen Road,	#320, I	Laurel, N	4D 20707	<i>'</i>	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 10 20	32. Registrar's Sign	ature A	wife					

			1 = State Amend Item 27	State of M per Dr.	Maryland / [,G847,09	epartmer Certifica	t of H	ealth and Death	Mental Hy	giene Reg. No.	005	06539
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medi		Shirle	y Mae Fl	ood				Februa			6:11P M
1	Examir		4a. Facility Name (If not institution, give		r)			Location of Dea	ath		County of Death	
			Holy Cross Hospit 5. Social Security Number 6. Se		nge (In yrs. last birt		ver S	Pring	S O Data of Bi		ontgomen	
	Funeral Director			744 eme		Yrs. Months		Hours Mi		ay, Year)	Cou	place (State or Foreign intry)
			Usual Residence of Decedent				1		Jan.20	5,1955	3 Verm	nont
	rylan how		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	Be-1 s	cto	Maryland Prince Ge	eorge	Clint	on						1 ☐ Yes 2 No
	or 21	Director	10e. Street and Number	D .			p Code			10g. Citiz	en of What Cou	intry?
	s 23e	Funerai	12509 Applecross	Drive 12. Was Deceder	t Ever in 11 C		20735		/C	- 1	USA 4. Race - Ameri	and fading
	Item Item	in.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	If Yes, spe	cify Cuba	n, Mexican, Pu	(Specify Yes or No orto Rican, etc.)	D- 1'	Black, White	
336	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 ☐ Yes	2 X No	Specify:		5	Specify: Wh	nite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show ha Medical Evaminar must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad	ication	16a.	Decedent's Usu	al Occupa	ation during most of w	ndina	16b. Kin	d of Business/Ir	ndustry
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	House	ise retired)	UKING	Λ+-	Home	
	led w lygier her th		12th 17. Father's Name (First, Middle, Last)			House	W116	40 14-45-4-11	/E'		Home	
and	ntal F ed of	Be		Cm					ame (First, Middle		sumame)	
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r treumatic event, the Med	To	Henry Orvid Emer		19b	Mailing Addres	s (Street a		M. Hadle Gural Route Numb		Town State Zi	n Code)
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28e-1 show other treumstic event. The Medical Examiner must be notified at		Jennifer Villalob		1	588 B 5						,
ē,	f Hearitem	- 3	20a. Method of Disposition	,	20b. Place of	Disposition (Na y, crematory or	ime of	oss uri	ve Clint	20c. Loc	ation - City or I	own, State
E O	Pages nent of int: If it		1 🕅 Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 🖈 ☐ Other (Specify)		0	rection	,	1	15/05	Clin	ton.MD.	
altimore,	교투분증 .		21. Signature of Funeral Service Licens	00					orge Kal			lome
<u> </u>	any is		Will Ma	lyh.					. Oxon H			
			23a. 1 1. Enter the diseas or comp block, or heart failure. List only o	lication that cause ne cause n each	ed the death. Do r line.	not enter the mo-	de of dying	g, such as cardi	ac or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Cardio	pulmonar;	y Arrest						Onset and Death
	/Medical Examiner		resulting in death)		is a consequence	·						
		5	Sequentially list conditions,		Myocardia		cctio	n			-	
	nsit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury		sclerotio		างลรด	ular Di	sease			
Ć,	execu n and ial-tra	Exai	that initiated events resulting in death) Last	U	is a consequence		, rabe	didi bi	beabe			
8760,	cate be executed physicien and the burial-transit	dicai		d								
9	ng ph	Med	IF FEMALE:						-			
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death					23	3d. Date of deliv Month	ery Day Year
	that the death ned by the atter detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown	at time of death	5 Other (s	pecify)					,
P.0	that the ed by detac		Part II. Other significant conditions co	ntributing to death	but not resulting in	the underlying	cause give	en in Part I.	23e. Did	tobacco us	e contribute to t	the cause of death?
Records,	iw requires that s been signed E should be deta	Completed by	Diabetes Mellitus,	Hyperten	sion,Res	pirator	y Fai	lue,Atr	ia ¹□	Yes 2 💢	No 3 □ Pro	bably 4 Unknown
00	w req	iete	Fibrillation, Chron	ic Renal	Failure	,Congest	tive	Heart	24a. Was	an	24b. Were auto	opsy findings available
	sicien: The law certificate has E irector, page 2 s	mo du	Failure and Systol	ic Dysfu	nction					ormed?	prior to co death? 1 ☐ Yes	empletion of cause of
of Vital		BeC	25. Was case referred to medical	it byota				26. Place of D	1 ☐ Yes eath (Check only	2XXNo one)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
	Physicien: this certificand director,	ToE	examiner? 1XXYes 2 □ No	Hospital: 1 ☐ Inpa	tient 2 √ ER/Ou	tpatient 3 D	OA Othe	er: 4 🗌 Nursing	Home 5 Res	idence 6	☐Other (Speci	fy)
0	ding Pl h. After ti funera		27. Manner of Death 1	28a. Date of In (Month, D			28c. Injury Work		28d. Describe	how injury	occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			М		res 2 □ No				
Division	l or Attendated after death Director:	Certification:	4 Homicide determined		njury - At home, fa etc. (Specify)	rm, street, factor	ry, office			wn, State)	Number or Hur	al Route Number,
	spitel ours a		29a. Certifier Certifying Phy	sician: To the bes	st of my knowledge	. death occurred	f at the tim	e date and pla	re and due to the	cause(s) a	and manner as	stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific decorpicities illed in by the funeral director.	Medical	(Check only 2 Medical Exami	iner: On the basis and manner:	or examination and	d/or investigation	n, in my op	pinion, death oc	curred at the time,	date and p	place, and due t	o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	Cunda	A		c. License				signed (Month,	Day, Year)
			* K. Shyan	15 WYOU			CCCU	0.7		2/12	2/05	
	(3)		30. Name and address of person who c				. 1 -	2-	0.0 : :		100	0070
			Shyamsundar Rajan,			estown I	kd. S	uite 20	2 Gaithe	rsbur	g,MD. 2	.0878
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 5 2005		strar's Signature	had.						
		rui	PED 1 0 2003	- Aller	BA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 2005 5:47 A.M Ralph A. Ferguson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year Mar. 9, 19 **Funeral** Days Hours Min Yrs 259-32-1845 76 Mar. Georgia Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's District Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20747 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene importent: if Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examples once. 6539 Pennsylvania Ave. United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Black Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Delivery Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert L. Ferguson Annie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Smith - Son 6704 Alpine St., #1; District Hgts., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 2/15/2005 Wash., DC * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 Person Mu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat • Dause (Final disease or condition resulting in death) Preumari **Physician** Moration /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nolov 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No his 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After t 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) FEB 1 5 2 2005

am



m1)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0055120

Win hinghen DC 20032

February 10 2005

			1 - State Registrar	State of Marylan	-	artment of F		Reg	CUUJ.	06541
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) Margaret Louise FI 4a. Facility Name (If not institution, give si		-	4b. City, Town, o	or Location of Dea	2. Date of Death Month Februal	Day , Year	5 2200 M
	Examin	er	Washington County			Hagers	stown		Washing	
	Funeral Director		5. Social Security Number 6. Sex 1位 1位			If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1922 Man	irthplace (State or Foreign Country) cyland
	land DW		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
;	Mary I sho	tor	Maryland Washing	ton	Funl	kstown				1⊠Yes 2□No
	or 28g	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	23a (ral	12 S. High Street			2173			USA	
0000	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In and Mental Franked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified at DDC.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 Ă No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2X No		Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh Specify: W	
0-617	Ithin 72 ho he. han "natur Medical J	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo d)	orking	6b. Kind of Busines	s/Industry
7	Hygier Hygier Ther th		17. Father's Name (First, Middle, Last)	0	none	2	18. Mother's Na	ame (First, Middle, M	none	
	d Mental harked of	To Be	Howard Earl Finfr		10h Maili	an Address (Chroni	Virgie	Shank		Zin Codel
20	id 2 sho ith and 27 Is m treum		Barbara Slifer - n	•	1	-		Rural Route Number, Boonsbor		
ē,	Hear Hear Hear Hear Hear Hear Hear Hear		20a. Method of Disposition	0	lace of Dispo	sition (Name of matory or other pla	!		Oc. Location - City of	
Ē	Pages nent of I ant: If it ury or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	n Cremat		L4/05 H	agerstown	, Maryland
Baitimor	permit. Pag Department Importent: any Injury o		21. Signature of Funeral Service License	Munu		Name and Address 15 E. Wil		MINNICH d., Hagers	FUNERAL town, Md.	
F	hysician		23a. Part1. Enter the disease, or complied shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line.	n. Do not ent	er the mode of dyi	,		st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of): Auu	Real	farl	lure	4	X Days
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a fonsequ	ience of):		\lor		(fdays
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n .	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of d Month	elivery Day Year
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r	0 - 0	omp	700000					autopsy perform	ed? death?	
	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one		
\ 10	Physicien: this certific ral director,	1º	1 ☐ Yes 2 ☐ No		ER/Outpatier	IT 3LI DOA		Home 5 ☐ Resider		ecity)
	After fune	tlon	27. Manne Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	nyat rk?]Yes 2∐No	28d. Describe hov	v injury occurred	
=	or At ifter c Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	the Hospitel thin 24 hours a the Funerel i mpletely filled	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Madical Exemin	ician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occ	e, and due to the cau curred at the time, dat	use(s) and manner are and place, and di	as stated. ue to the cause(s)
	To the Ho within 24 To the Fu completel	M	29b. Signature and title of certifier	(on, mi)		29c Licens	6655	J20	d. Date signed (Mod B. 12	2004
<i>A</i>	H-1		30. Name and address of person who co	mpleted cause of death (Item	23a) Typ e,	WiTe 2	00. H	sgas four	N, MO	21746
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Signa	ture	rested		-	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 10, 2005 **Physician** 9:22 am Grinage Flora /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PrinceGeorges Temple Hills 4413 23rd Parkway If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 67 March 23, 1937 Washington, 191-28-7752 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. snt: If item 27 is marked other then "natural; or items 23a or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 4413 23rd Parkway United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 genit. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☒ No Specify: Specify: Black þ 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roeine Griffin Raymond Gordon ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Grinage / Daughter 110½ Linn St. Washington, Pa. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dipartment of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Feb.15,2005 Washington, Pa. Washington Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. angl 701085 5538 Marlboro Pike/ Forestville, Md. 20747 Approximate Interval Between Onset and Death Part1. Ever the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic VInonary Discus-e **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 □ No 3 DOA Certification: To 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 10057680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5100 Auth Way Suitland, Md. 20746 Brett Kolpan, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Begin & Sporter Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Anna Suella Gipe 12 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown, Washington County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 80 219-14-9461 Director MD July 1,1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Mariest Examinary. 10a, Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Sharpsburg 1 Yes 2 No Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5019 General Anderson Court 21782 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💢 💢 0 <u>ک</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse Newton Mann Julia Mary Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14219 Gremlin Lane Hancock, MD 21750 Charles Gipe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate Feb. 16, 2005 Hagerstown, MD Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Cem. Donation 5 Other (Specify) Signature of Funeral Service Licensee Donald Edwin Thompson Funeral Home, Inc 7 rd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Conset and Death Immediale Cause (Final Pneumon, a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstructive HACKIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Coronary that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, oulcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Junknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No this certificate 1 ☐ Yes Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 00060396 114105 2 OPal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 WERL Hayer UN D MURSHED FARID 40 MD 31. Date filed (Month, Day, Year) 32. Réstrar's Signature FEB Millian Registrar

		For State	State of Ma		d / Depa		lealth and I	Mental Hyg	2000	06544
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) George Boyd Hess 4a. Facility Name (If not institution, give s Washington County			001		r Location of Death	2. Date of Deat Month	Day Year	5 01.44 AM
Funeral Director		5. Social Security Number 6. Sex			ast birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 2		irthplace (State or Foreign Country) PA
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should be file and Mental Hy marked oth	To Be (17. Father's Name (First, Middle, Last) Moses D. Hess 19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	g Address (Street	Loretta		Maiden Sumame) , City or Town, State,	, Zip Code)
Ore, Ma ges 1 and 2 s t of Health an if item 27 le or other trau		Dale Hess/Nephew 20a. Method of Disposition 1 XBurial 2 Cremation 3 P			715 Blace of Disposemetery, crem	renton S sition (Name of natory or other place	treet Sh	ippensbur Date	eg, PA 172 20c. Location - City of	257 or Town, State
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	Hygi nt,	e Co	17. Father's Name (First, Middle, La	ist)		Secre	lary		18. Mothe	r's Name	(First, Middle		ool Sy:	stem
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MOF	0		1 ☐ Burial 2 【Cremation 3		tate	emetery, crer	natory or oti	her place	re		4, 2005	Б		
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		Registrar 1. Decedent's Name (First, Middle, Last)			incate	of Death	2. Date of Dea			3. Time of Death
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/Medica Examine	_	a. Facility Name (If not institution, give s	treet and number)		4b. City, To	own, or Location of Dea		4c. County	of Death	
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uneral irector		220-30-9799	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Months			1910	9. Birthplac Country MAI	ce (State or Foreign RYLAND
M T	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d	d. Inside City Limits
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9		10e. Street and Number			10f. Zip C	21713		10g. Citizen of t		
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; f	To Be	CHARLES EDWARD HAM	MOND			LEIDA	ADA VANA	SDLEN		
		19a. Informant's Name/Relationship (Ty) ROBERTA E. SMITH,				Street and Number or F				-
other	-	20a. Method of Disposition	20b. F	Place of Dispo	sition (Name	of	Date	20c. Location -		n, State
5		1 ☐ Burial 2 🕅 Cremation 3 ☐ R 4 ☐ Denation 5 ☐ Other (Specify)		emetery, cren ATTHSBL		EMATORY 2/1	5/2005	SMTTHS	BURG.	MARYLAND
any injury or other tra	-	21. Signature of Funeral Service Licens				Address of Facility		LD NATI		
S G		Days Mall	Paul M. De	ean I	BAST F	UNERAL HOME		ORO, MA		
		23a. Part1. Enter the disease, of complishock, or heart failure. List only or	cations that caused the deat e cause on each line.	h. Do not ente	er the mode	of dying, such as cardia			A	Approximate nterval Between
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ed bi	D D	Certicome +	oth buen	~			1 🗆 Y	es 2 □ No	3 Probab	oly 4 Unknown
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age 2	Completed by						autop: perfor 1 Yes	med?	prior to comp death? 1 Yes 2	Dietion of cause of
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die die	To	examiner? 1 ☐ Yes 2 ☐ Ho	ospital: 1 Inpatient 2	ER/Outpatien	it 3 DOA	Other: 4 4 Nursing	Home 5 Resid	ence 6 Oth	ner (Specify)	
a funeral di	ation:	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 286	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occur	red	
completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, factory,	office	28f. Location (S City or Tow		ber or Rural F	Route Number,
e Funera letely filk	Medical (29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examin	ician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death	h occurred at vestigation, in	the time, date and place my opinion, death occ	e, and due to the curred at the time, o	cause(s) and ma date and place,	anner as state and due to th	ed. ne cause(s)
COMP	Me	29b. Signature and title of certifier			29c.	License number		29d. Date signe		* * * * * * * * * * * * * * * * * * * *
>		- (But ME			D	18019		FEB (4.2	7 = Y
	t	30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)					
1	-									

		1	For State Registrar	State of Marylar		artment of I			iene,	005	06548
Phys	iciar		. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day	Year	3. Time of Death
/Me	dica	l -	Dorothy Edith Ha a. Fecility Name (If not institution, give			4h City Town	or Location of Dea	January	_	2005 County of Dea	10:30P M
Exan	nine	4	9440 Newbridge D			Poton		atti		ntgome	
Funer	al	5.	Social Security Number 6. Securi	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr				thplace (State or Foreign ountry)
Directo	or		221-16-2398	□M 20XF 78	Yrs.	lilonaris Days	110013	Jan 1,	1927	7 De	laware
land ow		-	Sual Residence of Decedent Oa. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
a-f sh	3	2	Maryland Montgo	mery Po	otomac						1 ☐ Yes 2 🛣 No
ith the	1	ruilerai Director	0e. Street and Number			10f. Zip Code		1	0g. Citize	en of What C	ountry?
sath w	3	2	9440 Newbridge D		6 40	20854		(Casaita Van an Na	USA	Dese to	to dian
fter de		ו בולים מולים	Marital Status Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No	.5. 13.	If Yes, specify Cut	pan, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	1	4. Race - Ame Black, Whit	
rail, o	1	2	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2M∏No	Specify:		3	Specify:	White
72 h	1	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occu kind of work done	during most of w	orking	16b. Kin	d of Business	/Industry
withir than than	1	d	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT use retire</i> nemaker) (1)		Owi	n Home	
il Hygi	3	1	7. Father's Name (First, Middle, Last)		11011	icina ici	18. Mother's Na	ame (First, Middle,			
wid by Menta Menta srked	1	2	Francis Lynam				Marguer	rite Grays	ston		
2 sho and is ma		1	9a. Informant's Name/Relationship (7	Type, Print)	1			Rural Route Number			Zip Code)
1 and 1 and Health		2	Mark Hadley/Son Oa. Method of Disposition	20b. F	1210	S. Monro	e St, Ar	lington,		22204 ation - City or	Town State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departurent of Heelih and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at	0		1 ☐XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	TIGHTOVAL HOLL STATE		sition (Name of natory or other pla Nat'1 Ce	l l	3, 2005			
mit. Pages partment of portent: if it	9	2	21. Signature of Funeral Service Licen					erly Whea		iangle: / Fune:	
2 5 5 E	ä		· alang	Donnell				Rd, Alexan	_		
	ı		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dyi	ing, such as cardi	ac or respiratory arr	est,		Approximate Interval Between Onset and Death
Physicia /Medica		- 0	mmediate Cause (Final disease or condition resulting in death)	WI		erotic (Cardiovas	cular Dis	sease	2	Oriodi ario Dodin
Examine				Due to (or as a conseq	uence of):						
7 7	à	id id	Sequentially list conditions, any, leading to immediate	Due to (or as a conseq	uence of):						
ecuter and trans	Evamina	ti ti	Cause (Disease or injury hat initiated events esulting in death) Last	C. Due to (crise a consecutive)	wasaa of):					1	
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Į.	9		Due to (or as a conseq	quence or).						
ificate g phys	- ₹	3		. d							
leath certifica attending ph	huelolan/Mo	2 2	So, was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	ev.		23	d. Date of de	,
ires that the death cer signed by the attendin d be detached for use	100		in the past 12 months? 1 ☐ Yes 2 🌠 No 9 ☐ Unknown	4☐Pregnant at time of d 9☐ Unknown		Other (specify) _				Month	Day Year
that the ed by detacl	0	- p	art II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlving cause di	ven in Part I.	23e. Did tol	acco use	e contribute to	the cause of death?
uires rign	7	2				, , , , , , ,		1 □ Ye	s 2 🗆	No 3□Pr	obably 4 🙀Unknown
aw requir	potologo							24a. Wasa		24b. Were au	utopsy findings available
vicien: The lav certificate hes rector, page 2	1	5			-			autops perform	ned?	death?	completion of cause of
cian: ertifica actor,	0 0	2	5. Was case referred to medical examiner?					eath (Check only on	e)		
Physic this of all directions and the second	F		1X Yes 2 □ No 7. Manner of Death		ER/Outpatier	t 3 DOA	her: 4 Nursing	Home 5 Reside			cify)
ding th. After funer	2	<u></u>	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No	28d. Describe ho	ow injury	occurred	
or Attending I after death. Director; After in by the funer	Cortification.	2	3 Suicide 6 Could not be determined		ome, farm, str	eet, factory, office		28f. Location (St City or Town		Number or Ri	ural Route Number,
ital or raft Dir			7 Nomicido	Building, etc. (Specif				Ony or row	, State/		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	lealba	2		ysician: To the best of my kno niner: On the basis of examina							
o the o the omple	Mod		9b. Signature and title of certifier	and manner stated.	11 1	29c. Licens	se number	2	9d. Date	signed (Mont	h, Day, Year)
3	İ		Faturia 10	mske May	, mos	+	D59196		Feb	ruary	8, 2005
دے		3	0. Name and address of person who o							-	
	1		Patricia Tomsko			ille Pk,	G-100,	Rockville	, MI	20852	2
Regio	State	3	1. Date filed (Month, Day, Year)	32 Aegistrar's Signa	H. Ac	wer					

			For State		d / Depa	artment of He	ealth and Mo	ental Hygi	iene	06549
	Physici	an				10				3. Time of Death
	/Media	cal	4a Facility Name (If not institution dive		7111711		ocation of Death	2	4c. County of Death	19: -P M
	Physician Physician Physician Physician Physician As Facility Name (if not isstitution, give street and number) CAROL ANN HEAD 2. Date of Death As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution, give street and number) As Facility Name (if not isstitution) As Facility Name (if not iss			CARROLI						
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	a Rinth	nplace (State or Foreign untry)
	ס		Usual Residence of Decedent	1 05				9/9/19	939 MAR	YLAND
	Marylar I show	tor			-					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 288	Olrec	10e. Street and Number					10	Og. Citizen of What Co	untry?
	s 23a	rai							USA	
920	urs after de ai', or items	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give				cify Yes or No- lican, etc.)	14. Race - Amer Black, White Specify: WH	rican Indian, e, etc. I TE
15-0	in 72 hou n "nature	oleted	(Specify only highest grad	de completed)	16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	ion uring most of workin	g	16b. Kind of Business/I	ndustry
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Mar	2 sho			•		-				
	1 and Health em 27		20a Method of Disposition	20h F	Place of Disno	sition (Name of			NSTER, ML 20c. Location - City or 1	
101	Pages ent of nt: If it		1 M Burial 2 □ Cremation 3 □ F	Removal from State ZION	semetery, crei V CHUF	natory or other place, RCH CEM.	2/13/		ESTMINST	
Balti	permit. P Departm Importar any inju				22	2. Name and Address				
	/Medical Examiner	xaminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I am John Cause. Enter Underlying Cause (Disease or injury that initiated events	a	quence of):	er the mode of dying,	Secondary Control of the Control of	T CA	NCER	Approximate Interval Between Onset and Death
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	luires that n signed t	d by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giver	n in Part I.		acco use contribute to s 2 No 3 □ Pro	the cause of death?
II Reco	The ate h	Complete	TIMPE1	RTENSIO	N.			autopsy perform	prior to c ed? death?	opsy findings available ompletion of cause of
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ion	nding ath. r: Afte e fune	atlor		(Month, Day Year)	Injury		_			
Divis	al or Atta a after de i Directo d in by th	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office	2		eet and Number or Rui , State)	ral Route Number,
	To the Hospitel or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	vsician: To the best of my knoiner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my opin	e, date and place, and nion, death occurre	nd due to the ca d at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0/110		29c. License	number	29	d. Date signed (Month	. Day, Year)
•	WIL		NICO	Doloro		D.565	64		2.9.	
	4		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	Print) wh	won H	15 h	2.9.9	1159
	Sta Regist		31. Date filed (Month, Day, Year) FFR 1 1	32. Registrar's Signa	ature	1. W.				

DHMH 17 Rev 1/2001

ORIGINAL

			State		partment of He <i>ertificate of D</i>			2000	06550
			1. Decedent's Name (First, Middle, Last)		Crimodic of D	Call			3. Time of Death
	Physici		Julia Rebecca H	awkins			1 Month	Day Year	0 0
	/Medic		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or L	ocation of Death	## Ac. County of Death ## Ac.	117	
	Examin	ier	Harland Memoral H	as the	Han	0. 1. 6	111-0	il a	- D
	Funeral			ge (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9 Bir	thplace (State or Foreign
ш	Director		215–12–0517 1 M 2 XF	93 Yrs	Months Days	Hours Min.	Feb 9,	1912 Ma	ountry)
	٥ ,		Usual Residence of Decedent	T40 01 -					,
-	arylar ahow	_	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits
	8e-f	Director	Maryland Harford	1	Havre de	e Grace			1 ☐ Yes 2X No
	with the		10e. Street and Number 517 Alliance Street		10f. Zip Code	1070	1		ountry?
:	s 23	Funeral		Surviville 14		1078			
	Item Item	j.	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Vas Decedent 1 □ Vas Decedent 1 □ Vas Decedent 1 □ Vas Decedent 1 □ Vas Decedent 1 □ Vas Decedent 1 □ Vas Decedent	?	 Was Decedent of Hist If Yes, specify Cuban, 	, Mexican, Puerto	Rican, etc.)		
39	urs at	by	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Bl	ack
Ŏ.	72 hours after death with the Maryland Inetural', or Items 23a or 28e-f ahow dital Examiner must be notified a	Completed	15. Decedent's Education	16a. De	cedent's Usual Occupati	ion		16b. Kind of Business	/Industry
215	within 7 ene. than "r	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+1	ive kind of work done du a. DO NOT use retired)	iring most of work			
21	Hygien Hygien other th	Con	8	Di	etician				1
pu	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, I'm M.	Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Name	e (First, Middle, I	Maiden Surname)	
<u>\</u>	should nd Men marka umatic	ပ္	Harry Durbin				ınknown)		
-	s 1 and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene. If Health and Mental Hygiene is the Italian 23a or 28e-1 ahow tem 21 a markad other than "netural", or liems 23a or 28e-1 ahow other traumatic evant, If a Mcdcal Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)						
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no	Pages nent of I int: If its iry or o		1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 3 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, c	rematory or other place)	1			
			21. Signature of Funeral Service Licensee	Sc. Daile	es United C	of Facility			
m	permit. Departn Imports any inju		I disa Scott	El El	Lisa Sc	cott Fune	eral Hom	e, P.A.	MD 21070
	- 1		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not	enter the mode of dying,	such as cardiac	or respiratory arm	e de Grace	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	3 A.	tia Ca	0	P	1 -	Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 06551 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2005 7:45A M 15, HAMMERER FEB. N/M/N/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLES 24 BOBWHITE CT. LA PLATA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN . 15, 1923 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 82 Director GERMANY 097-16-7188 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Healith and Mental Hygiene.
anst if Item 27 is marked other than "natural; or Items 23a or 28e-1 show usy or other than try or other treumatic event, the Medical Estatrics count be notified at LA PLATA Myes 2 □ No MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā U.S.A. 24 BOBWHITE COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ 13. Was Decedent of H If Yes, specify Cuba If Yes, Give Year or Dates 1943-1973 1 □ Yes 2 🗓 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify: à 3∰Vidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USAF-US GOVT. RET. LT. COLONEL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LUISE KAISER JOHN HAMMERER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45240 COVE MANOR RD., CALIFORNIA, MD 20619 ROLF HAMMERER-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o tXDeurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL CEM. 4-8-05 ALINGTON, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 Ma AYMOND FUNERAL SERVICE, PA T 3 DI ATTA MARVITAND 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE CHRONIC OBSTRUCTIVE **Physician** /Medical PULMONMY DISCORD Due to (or as a consequence of) **Examiner** Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2□ No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 28 No nerel Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours 29a. Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AHENDING D 44436 46) ally 15 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 102 PAUL MELION CT PATEL WALDORF MD 20602 ASHVINKUMAR 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Sparker FFR 8 8 2005 Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** January 2005 Margaret Drisko Haynes 3:40PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Williamsport Homewood Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Sept 7) 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 92 Yrs. Virginia Director 214-03-8216 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mountal Examinar is ust be notified at 1 ☐ Yes 2 No Directo Virginia Lake Ridge 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 12111 Stallion Court 22192 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter 1X Never Married 2 Married 1□ Yes Ž No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Loan Institute 11 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Augustus Poindexter Haynes Elizabeth Dunlap 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna H. Wheeler (niece) 12111 Court Lake Ridge Virginia 22192 20b. Place of Disposition (Name of Eventury, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot ang.e. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Feb 10 2005 Alexandria Virginia Wheatley Crematory 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclorotic Cardiovascular Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) _ ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been sign rector, page 2 should be Congestive Heart Failure Artial Fibrilation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print) 1Pu 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar FFB 2 8 2005

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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumetic event, the Medical Examinar must be invilled at once.	by Funeral Director	1 Never Married 2 Married	Agmed Forces?		If Yes, spec		n, Mexican Specify:	, Puèrto I	cify Yes or No- Rican, etc.)		Black, White Specify: BL	e, etc.	
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e G	1 and Healt tam 2		20a. Method of Disposition	-	Place of Dispo	osition (Nan	ne of	Ţ		ate		cation - City or		
Baltimore,	ages ant of it: If it		1 🕅 Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe	□Removal from State	cemetery, cre RLINGTO	-			-23-0)5	ART.T	NGTON,	VIRGIN	JΤΔ
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	ires sigr 1 be	by	Part II. Other significant condition	s contributing to death but not re	esulting in the u	underlying c	ause give	ın in Part I.		23e. Did to		ise contribute to	the cause of	
of Vital Records,		Completed								24a. Was autop perfo 1 🗆 Yes	SV	prior to death?	utopsy finding completion of 2 \(\text{No} \)	
ita	sician: Th certificate rector. pag	Be (25. Was case referred to medical examiner?				1140		of Death	(Check only o	ne)			
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	To the Hospitel or Al within 24 hours after of To the Funaral Direc completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my kr aminer: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred nvestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause)(s)
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3	(0-5)		Mudell	Geles	mo		D532	209				2-10	-05	
	(20)		30. Name and address of person what WARDELL PIERS	OM M D	3001 -	HOSPIT	TAZ	DRI	Æ	CH	EVE	2-10 RLY, N	1) 20	185
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 5 20	2 Registrar's Sign	nature_	21								

		Please Ty	pe or Print in Bla	ick Ind	delible Ink. Ensure A	II Copies A	e Legible.	
		1 - For 2-23-05 Registrar Ameno#'s10e.19a.			rtment of Health and Natificate of Death	Mental Hygie	6000	06554
Physicia	an .	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medic	al.	Roderick J. Jo 4a. Facility Name (If not institution, give stre			4b. City, Town, or Location of Death	tebruary	4c. County of Dea	1205 P M
Examin	er	Doctors Community			Lanham	·	Prince G	
Funeral Director		377 70 3372	7. Age (In yrs. last 84	birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 24	9. Bir	thplace (State or Foreign ountry) Jamaica
land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation			10d. Inside City Limits
Mary 1-1 eho	tor	MD Prince Geo	rges Lanh	am				1 ÖYes 2 □ No
or 282	Funeral Director	10e. Street and Number . Chervil			10f. Zip Code	10g.	Citizen of What C	ountry?
s 23e	rail	8607 Chevil Rd.	Was Danadash Evenia H.C.	10.1	20706		USA 14. Race - Am	of and Indian
fter de	Fune	11. Marital Status 12. 1 □ Never Married 2 ☒ Married	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2/2/No		Vas Decedent of Hispanic Origin? (SI Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, Whi	
ours a	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	Yes XXNo Specify:		Specify: B1	ack
"netu	ietec	15. Decedent's Educati (Specify only highest grade co	ion 1- ompleted)	(Give	ent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16	o, Kind of Business	/Industry
withir iene. rthen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	<i></i> 0. c	Tailor		Private	
e filed al Hyg I other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Mai	den Sumame)	
ould b Ment Parkec	Tol	Ezekiel Johnson	_			Quarrie		
d 2 sh th and 7 Is m traum		19a Intorment's Name/Relationship (Type, TWY INC IVY E. Johnson/Wife		19b. Mailin 9607	g Address <i>(Street and Number or Ru</i> Chervil Chevil Rd. Lanha:	ral Route Number, C	ity or Town, State, .	Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23e or 28e-f ehow empty injury or other traumetic event. It e Madical Examinar must be notified at once.		20a. Method of Disposition			sition (Name of natory or other place)		c. Location - City or	Town, State
Pages nent of nt: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 1 ☐ Donation 5 ☐ Other (Specify)	IOVAL HOLL STATE		!	19,2005 Br	entwood	MD
permit. Departm Importa eny inju		21. Signature of Funeral Service Licensee	1 V		Name and Address of Facility Jo	hnson & Je	nkins Fu	neral Home
20 E 9 9		Menage	sent in		16 Kennedy St. N			
Pnysician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one disease or condition resulting in death)	cause on each line.		or the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death ITOUR S
/Medical Examiner		Tosting in death)	Dysr HyTH					MINUTES
à,	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent					111111111111111111111111111111111111111
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To the Hospital or Attending Physicien: The law requires that the death certificate be exe within 24 hours after death. To thie Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician are completely filled in by the funeral director, page 2 should be detached for use as the burial-time.	Physician/Medicai	in the past 12 months? 1 □ Yes 2 □ No	If yes, outcome of pregnancy Live birth 2 Fetal dead Pregnant at time of death Unknown	ath 3□	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
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w requir been si should I	ompieted	HYPERTENS				24a. Was an	24h Were a	utopsy findings available
sicien: The law certificate has t irector, page 2 s	dmo	TIPERTENS	,,,,,			autopsy performed	prior to death?	completion of cause of
ien:] rtifical	Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 ☐ th (Check only one)	No 1 □ Yes	2 □ No
Physicien: this certific al director,	ပ္	I Tes 2 VIVO	pital: 1 Inpatient 2 ER/			ome 5 Residence		cify)
ding Phys h. After this funeral di	ion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
Attend death octor: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home	, farm, stre		28f. Location (Stree		ural Route Number,
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To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai (29a. Certifier 1 Certifying Physici (Check only one) 1 Medical Examiner	an: To the best of my knowled: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, date and place, restigation, in my opinion, death occur	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	1 1 1 1		29c. License number		Date signed (Mont	
		* Sholar	AROI	CA	20059675		2/9/05	am-
(5)		30. Name and address of person who comp			Print) PCIAD / ANIL	Am man	11 010 2	ACM.

Registrar DHMH 17 Rev 1/2001

State

8118 GCOD LUCIC ROAD
Registrar's Signature

LANHAM, MARYLAND 20706

SHOBHIT ARORA
31. Date filed (Month, Day, Year)
FEB 1 5 2005

_	To the Hospitel is within 24 hours a To the Funeral Completely filled in	edicai	29a. Certifier Certifying Phy							and place, and	er as stated.
Division	or Atten fter deat lirector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	(y)	reet, factory,	office	28f. L	City or Town, S	State) Se(s) and mann	or Rural Route Number,
ō	Phys this ral dii	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 □ Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	-	Other	ursing Home 28d.	5 Residence	e 6 Other	, ,
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Δ.	w requires that the been signed by should be detailed	þ	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the u	nderlying cau	use given in Part I	l. :		co use contribu	ute to the cause of death?
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Baltimore,	permit. Pag Departmen Importent: any injury once.		21. Signature of Funeral Service Licens		22	2. Name and	Address of Facili	y Geral	d N. M	innich	Funeral Home MD 21740
	9 = 5		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ P 1 □ Donation 5 □ Other (Specify)		Place of Dispo emetery, crer	sition (Name natory or oth	-	Date	200		ty or Town, State
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or iteme 23a or 28a-f show other traumatic avent, I'm Medical Examinating Indillied at	by Funer	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	1		nt of Hispanic Ori y Cuban, Mexicar X No Specify:		res or No- i, etc.)		American Indian, White, etc. Black
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		. \$	Avalon Manor 5. Social Security Number 6. Sex		last birthday)	If Under 1		24 Hrs. 8. D	ate of Birth fonth, Day, Ye	Washi	ngton Birthplace (State or Foreign Country)
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		137 010	1. Decedent's Name (First, Middle, Last)		001	incate	Or Death		ate of Death	Day Y	3. Time of Death
		-	For State	State of Marylan	Cer		of Death		Reg.	No UU	5 06555

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	/Media	al .	Lillian Ann JEWET				45 0% 7				February		2005	05:35 a	L . M
	Examir	ier	4a. Facility Name (If not institution, give : Homewood at Willia						Location of			4c. County			
	Funeral		5. Social Security Number 6. Sex		e (In yrs. las	st birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birth		ingt 9. Birth	olace (State or Fo	oreign
	Director		131-09-9263	M 224F	95	Yrs.	Months	Days	Hours	Min.	(Month, Day, Aug. 24,	1909		w York	
	pu »		Usual Residence of Decedent 10a. State 10b. County		10a City	Town or Lo									
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9	after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give	No	1	rYes,speci I⊡ Yes 2		s, Mexican, Specify:	, Puerto F	Hican, etc.)	100	ck, White,		
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Maryland	should be mad he mad auma		19a. Informant's Name/Relationship (Ty								Route Number,				
	and 3		Marilyn Tracey -	daughter	201 201		-		Lane		gerstown				
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Ħ	artmeni ortant: Injury		'4 □Donation 5 □ Other (Specify)		Hage	erstow							_	, Maryla	nd
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funarat Service License	Mus	unid	41		Wils	on B	lvđ.	MINNIC , Hagers	town,			
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	To the within To the comp	Me	29b. Signature and title of certifier				29c.	License	/	200		d. Date signer	d (Month,	Day, Year)	
•			· /M	1 /				1) 0	08	06	F	Chro	11	2005	-
			30. Name and address of person who co	mpleted cause of d	eath (Item 2	(Type, I	Print)	1.	use	10	1-0-1	(1.0	>/\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	_
2	O, ペー/ Sta Registi	- 1	31. Date filed (Month, Tay, Year)	32. Registr	ar's Signatur	I HO	and I	X LP	Wil	17	rgesta	m	دام	471.	_

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 4, 2005 **Physician** Jenkins 4:36 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health-Circle Manor Kensington Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | June 26, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 TM 2 TF 214-14-2270 89 Yrs Washington, DC Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location iiit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "neturel; or items 23a or 28e-f ehow njury or other treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Kensington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10817 Hobson Street 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1½∏Yes 2 ☐ No If Yes, Give Year or Dates:1942-43 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Firefighter Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy T. Jenkins Cora E. Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney G. Springirth/ Nephew 133 Crystal Spring Drive, Ashton, MD 20861 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State February 10 Parklawn Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rockville, Maryland permit.
Departminimporta
any nju 21. Signature of Funeral Service Licers 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 Days disease or condition resulting in death) Fracture of Left Pelvis /Medical Due to (or as a consequence of): m om E **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760 05 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.O. the Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by eq Metastatic Cancer of Prostate, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Congestive Heart Failure, 24a. Was an has autopsy performed? Yes 2 \(\frac{1}{2}\) No 1 ☐ Yes 2 ☐ No Division of Vital Organic Brain Syndrome 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: XXX Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Tripped on rug in bedroom death. 1 ☐ Yes 2 🔀 No investigation 1/26/2005 11:30a M 2 Accident Director 6 Could not be determined 3 Suicide thin 24 hours after de the Funeral Director mpletely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10817 Hobson St. Kensington, MD 20895 4 Momicide Patient's Home 29a. Certifier 灯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 7, 2005 D12121 30. Same and address of or rson who sompleted ca of death (Item 23a) (Type, Print) George Senystack, M.D. 3929 Ferrara Drive, Wheaton, Md 20902 Registrar's Signature 31. Date filed (Month, Day, Year) 1 0 2005 Registrar

			1 - For State Registrar	State of Mar		epartm <i>Certific</i>			ind Ment	al Hygien	_ U U	15	06558
I	Physici /Medic		1. Decedent's Name (First, Middle, Las				ARA		FE	BRUARY		Year 2005	3. Time of Death
	Examin Funeral Director	er	5. Social Security Number 6. S	KINS HOS	5 P1 + A In yrs. last birt	AL B	A H Name of the American Ameri	If Under 2	24 Hrs. 8. Ba Min. (M	ite of Birth onth, Day, Yea		9. Birthpi Coun	* *
	P		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	n or Location				2-15-19	43 1	77 87	via, Liberi Od. Inside City Limits
	r 28a-f sh	irector	Md Montgome	ery	Serd	irick 10f	. Zip Code			10g. C	itizen of V	What Coun	Yes 2□No try?
	3a o	Ü	178 Key Parkway				2170	2		Т.	iberi	1 9	
336	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mentat Hygiene. If item 27 ia marked other than "natural", or Itams 23a or 28a-f show or other traumatic avent, the Medical Examinat must be natified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S.	If Yes,	ecedent of Hi	spanic Orig	gin? (Specify Y , Puerto Rican,	es or No-	14. Rao Blac	e - America ck, White, c	etc.
21215-0036	within 72 hounds one. Ithen "neture or Modical is	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a.	Decedent's l (Give kind o. life. DO NO	f work done d T use retired	furing most)		16b.		usiness/Ind	-
7	filed Hygie other ent, II		17. Father's Name (First, Middle, Last)	4yrs			Schoo			, Middle, Maide			.1
Maryland	2 should be filed with and Mental Hygiene Is marked othar than sumatic avent, Ire	To Be	Arthur Gray					Loui	se Neal	L			
Nar	2 sh and la m raum		19a. Informant's Name/Relationship (19a. Ethel Kamara	Type, Print)		-				e Number, City			
	1 and 3 Health tam 27				20b. Place of			e St.	Philac	lelphia			
10	ges at of the		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cem eter	y, crematory	or other place	· 1			_ocation -	City or To	wn, State
Baltimore,	t. Partmer		* 4 ☐ Docation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Neal Co		d, Plo		3-14-05				iberia
Ba	Depa Impo any ir		+ Harry &	Shesin	belle	1425	Mary1	and A	ve., N.	E. Wash			uary Inc. 20002
	Physician /Medical		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a HYPOT	ENSI	ON	mode of dying	g, such as c	cardiac or respi	ratory arrest,		ú	Approximate Interval Between Onset and Death WHOUKS
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a control of the co	EPS1	is						4	DAYS
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c									
.O. Box 6	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tim 9 Unknown	Fetal death	3 □Ectop 5 □ Other	ic pregnancy (specify)				23d. Dat Mor	e of deliver	ry Day Year
rds, P	signe d be	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying	ng cause give	en in Part I.	23		use contr		e cause of death? ably 4 □Unknown
Vital Records,		Completed								la. Was an autopsy performed? Yes 2 X N	D	prior to com	psy findings available appletion of cause of
<u>K</u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho		of Death (Chec	ck only one)			
Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 ER/Out (ear) 28b. Ti		28c. Injury Work	4 🗀 1901	28d. D	Residence)
Divis	al or Atta s after de il Diracto ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, far Specify)	rm, street, fac	ctory, office		28f. Lo Ci	cation (Street a ty or Town, Sta	nd Numbe (e)	er or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Direct completely filled in the funeral birect completely filled in the funeral birect filled in the funer	edicai (29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exam	ysicien: To the best of r niner: On the basis of ex and manner stated	amination and	, death occur d/or investiga	red at the tim tion, in my op	e, date and inion, death	place, and du h occurred at th	e to the cause(ne time, date ar	s) and mar d place, a	nner as sta and due to	ited. the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier				29c. License			29d. D	ate signed	Month, E	lay, Year)
1			1.18	MP			1155	-000	0	FEB.	RUAL	RY 1	4,2005
	(5)		30. Name and address of person who GERALD BLOOM F 31. Date filed (Month, Day, Year) FEB 1 5 2005	completed cause of deal	th (Item 23a) (Type, Print)	HUSPI,	TAL	BACTIM	ORE, MA	CYLAN	10 8	21287
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 2005	2. Registrar's	Signature	book							

		•	For State Registrar	State of N	Maryland / Depa	artment of H			giene ()	05 06559
	Physici /Medic Examin	al	Decedent's Name (First, Middle) Or \ 4a. Facility Name (If not institution,	Keller	r)	4b. City, Town, or	Location of		Day 12	3. Time of Death 7: 10 @M of Death
	Funeral Director	CI	Solumis	NAMA	Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birtl Min. Sept. 8	7 Year) 1921	9. Birthplace (State or Foreign County) Maryland
	ס	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Calve	rt	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XNo
	ath with the 23e or 28e	Funeral Director	10e. Street and Number 13325 Dowell Ro			10f. Zip Code 2068			U.S.	Α.
9200	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Modical Examilier mat be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	₫ No	Was Decedent of Hi If Yes, specify Cubai 1 ☐ Yes 2 ☑ No		n? (Specify Yes or No- Puerto Rican, etc.)	Specify	e-American Indian, ck, White, etc. : White
21215-0036	s 1 and 2 should be filed within 72 hours after death with tha Marylan if Health and Mental Hygiene. Item 27 is markad other than "natural", or Items 23a or 28a-1 show item 27 is markad other than "natural", or Items 23a or 28a-1 show other traumatic event, I're Mudical Examilier real be notified.	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12) 0-12	s Education t grade completed) College (1-40	(Give	dent's Usual Occupa kind of work done a DO NOT use retired,	lurina most c	of working		usiness/Industry
Maryland	2 should be filed withing and Mental Hygiene. is markad othar than aumatic event, It's M	To Be (17. Father's Name (First, Middle, L Charle	1	Houck			s Name <i>(First, Middl</i> e, Mary	Beck	
	1 and 2 sho Health and I am 27 is ma thar trauma	•	19a. Informant's Name/Relationsh Mary Sothoron —					or Rural Route Numbe		State, Zip Code) ry1and 20653
Baltimore,	Page ment o ant: If ury or		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp.	ecity)	Highland	matory or other place View Cem	etery	Feb. 16,2005	Sykesvi	City or Town, State
Balt	parmit. Pag Department Important: I any injury o once.		21. Signatur d Fineral Service L	icensee //				Minnich Fu Blvd., Hag		Home n, Maryland 2174
8760,	cate be executed by yellow the buriat-transit the b	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or a	as a consequence of):	a) Pailv	rc 1/,†~1	iniac of respiratory an	651,	Approximate Interval Between Onset and Death 2 1
P.O. Box 68	The law requires that the death certificate be executed tite has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Da Mo	te of delivery nth Day Year
	uires that signad by d be deta	by	Part II. Other significant conditio	-	but not resulting in the u	inderlying cause give	en in Part I.		bacco use cont	ribute to the cause of death? 3 Probably 4 Winknown
Il Records,	ilcian: The law requir certificate has been si rector, page 2 should I	Completed	dorte s	hart for	Ive			24a. Was a autop perfor 1 Tyes	med?	Were autopsy findings available prior to completion of cause of death? Yes 2 No
of Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	atient 2 ER/Outpatie	othe Othe		of Death <i>(Check only of</i>		a. (Sa-it.)
ion of	ding Aftar fune	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Ir (Month, L		of 28c. Injury Work	at	28d. Describe h		
Division	tal or Attanus after death	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of	Injury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basis and manner	st of my knowledge, deat t of examination and/or in stated.	ivestigation, in my op	oinion, death	place, and due to the o occurred at the time, o	ause(s) and ma date and place,	nner as stated. and due to the cause(s)
)	To t To t	M	29b. Signature and title of certifier	Mg.		29c. License		4	29d. Date signed	d (Month, Day, Year)
131	4-3		30. Name and address of person value of Paul V. Po	•			310.	Prince Fro	ederick	.Md. 20678
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1	32. Regi	strar's Signature	4 7	,			,

State of Maryland / Department of Health and Mental Hygiene

			, , , , , , , , , , , , , , , , , , , ,	Cen	tificate of	Death	,	Reg. No.	00000
П	Blooding	1. Decedent's Name (First, Middla, Las	· A ·				2. Date of De Month		3. Time of Death
	Physician /Medical	Jean Pa	role Kel	161			Februs	ry 11, 200 5	4:15 PM
	Examiner	4a Facility Name (If not institution, give		/		4b. City, Town, or Lo	ocation of Deat	-	
		Westminster		one		MESTIM		Carr	
	Funeral Director	213-32-9000	9x 7. Age (In yrs. □ M 2只 F 69	(ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sep 22		irthplace (State or Foraign Country) aryland
	snylend show	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	ation				10d. Inside City Limits
	vith the Ma t or 28a-1 s be notified	Maryland Carro	DTT		T	Mancheste	er		1 ☐ Yas 2 反 No
	ath with the Maryler 23s or 28s-f show wat be notified at	10e. Street and Number 3544 Rockdale Ro	oad		10f. Zip Code	21102		10g. Citizen of What C	Country?
215-020	ours after degraif, or items Examiner m	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		'as Decedent of H Yes, specify Cuba ☐ Yes 2 [X] No	tispanic Origin? (Spe an, Mexican, Puerto Spacify:	всіfy Yes or No Ricaп, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. white
ה ה	72 hg	15. Decedent's Ed (Specify only highast grad	ucation da complatad)	16a. Decede	ent's Usual Occup	ation during most of worki	ina	16b. Kind of Busines	s/Industry
1212	be filed within 72 ho tel Hygiene. d other than "natural ovent, the Medical and Be Completed	Elamentary/Secondary (0-12)	College (1-4or 5+)		o <i>not use retire</i> chine Op	during most of worki d) erator	g	Clothi	.ng
2	tel Hygie d other event, the	17. Father's Name (First, Middla, Last)	•			18. Mother's Name	First, Middla	, Maiden Sumama)	
land	Mente Mente Mente Irked Irked	Leslie Warren				Bessi	e Malba	iss	
Mar	ath and Men 27 is marke r traumatic	19a. Informant's Name/Relationship (7 Adam Kelley Sr,	• • • • • • • • • • • • • • • • • • • •					er, City or Town, Stata, cer, MD 211	
nore,	of Fee	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	ition <i>(Name of</i> atory or other place e Cemete	10	Date 2/16 2005	20c. Location - City of	
	permit. Pages Department of Important: If i any injury or once.	21. Signature of Funeral Service Licens		22.	Name and Addre	ss of Facility	Eline	Funeral Ho	ome
6		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the death					rest, MD 21	Approximate Interval Between
	Physician	Silvery of House Fallows. Else Brilly G	and dadde diff dadar into.						Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition	a Chenic	obstr	uctive	bulmon:	ory di	126326	7 4345
A.	-	resulting in death)	Due to (or	r as a consequ	ence of):		1		
'n	certificate be executed nding physician end use as the buriel-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):			MR 8-41-4	
00/00	icete be physicia s the bu	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):				(
ž.	certification of the second of		d						
0	death ne atter ed for u	Part II. Other significant conditions co	ptributing to doubt but not room	Iting in the use	larluina aguag air	on in Deat I	02h Did	tobases use sentribu	to to the series of death?
9	let the death ce d by the attend leteched for us Physician/	Part II. Other significant conditions to	nunbuling to death but not resu	iting in the und	ienying cause giv	en in Fait I.		1	te to the cause of death? Probably 4 Unknown
,	es thei igned i be det							.00 20.10 00.	
SCOLUS,	been s should						24a. Wes perfo	an autopsy 24b.	. Were autopsy findings available prior to completion of cause of death?
ב	The law in ete has by page 2 st						101	rus ziuliu	1 ☐ Yes 2 ☐ No
2	entifice ector, p	25. Was case referred to medical				26. Place of Death	(Check only o	one)	
<u> </u>	Physician: rthis certific oral director.	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3□ DOA Oth	er: 4 Nursing Hor	me 5 Resid	dence 6 □Other (Spa	acify)
	ith. : After the funeral	27. Many of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat 2 k? Yes 2 ∐ No	28d. Describe I	now injury occurred	
	tal or Attending P rs efter death. al Director: After t led in by the funers Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stree	et, factory, office	1	28f. Location (\$ City or Tox	Streat and Number or F vn, Stata)	Rural Route Numbar,
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl	29a. Certifier (Check only one)	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death o on and/or inve	occurred at the tin stigation, in my o	ne, date and plece, a pinion, death occurre	and due to the a	cause(s) and manner a date and place, and du	is steted. le to the cause(s)
	within of the omple	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date signed (Mon	oth, Day, Yaar)
	MJL	VAL	m () below	9	00	059943		Rbruary	11,2005
	W	30. Name and address of person who co	man ari	23a) (Type, Pr		Mo ZIIS	C. A.	Rbruary Del, M.G.	
	State	31. Date filed (Month, Day, Year)	32. Regintrar's Signat		0	211)	(
	Registrar	FEB 14	2005 Marie	K A	South D				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Recistrar Amended #7 per FH, FCHD tm02/C5/12/1902/te of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 6, 2005 1:30 p. M Irish Liljenquist /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** College View Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Firth
Months Days Hours Min.

June 29, 1917 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** 1 □ M 2 € Michigan 314-10-1572 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside Çity Limits 10b. County 10a State ?7 ia marked other than "naturai", or itams 23a or 28a-f show traumatic event, the Medical Exantrar must be notified at Frederick Frederick Maryland 1 Ves 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 U.S.A. 700 Toll House Avenue death \ Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "netural; or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No white Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Administrative Officer 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Natalie Howell George S. Irish ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health a important: if item 27 la any injury or other trauonce. 5041 King Richard Drive, Annandale, Virginia 22003 George H. Irish - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State FEB. 14, 2005 Frederick, Maryland 4 □Donation 5 □ Other (Specify) Frederick Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final disease of condition resulting in death)

Due to (or as a consequence) 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death DAY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the l 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Shursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

ي $\mathcal{J}_{\mathcal{M}} \mathcal{A} = \mathcal{J}_{\mathcal{M}} \mathcal{L}$ Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

the funeral

To the Hospital or Attending Physician: after death. filled in by 24 hours a

6 ☐ Could not be 3 🗌 Suicide 4 Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

FREDERICU MOD

29b. Signature and title of certifier

D-31912

29c. License number

0

within 2

State Registrar

completely

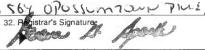
cai

29a. Certifier

(Check only

Julio MENOCALINA-156% 31. Date filed (Month, Day, Year) FEB 14 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



20

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nancy Lally February 11, 2005 9:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2504 Shelley Circle Unit 3B Frederick Frederick 8. Date of Birth (Month, Day, Year)
Jan. 27, 1934 7. Age (In yrs. last birthday).
71 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 232-50-5998 Director Yrs. Wharton, WVa Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Exeminer must be notified at Completed by Funeral Director Maryland Frederick Frederick XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21702 2504 Shelley Circle Unit 3B USA Items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2★ No Specify: White Specify: 3 ☐ Widowed 4 Privorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 McCoy, Jr. Nancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is: any injury or other training. 247 Lake Coventry Dr. Frederick, MD 21702 Laura Goodrich/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Fairfax City Cemetery 2/16/2005 Fairfax, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityStauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final POORLY PIFFERE PATED CANCER OF UNKNOWN PRIMARS Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 1 Yes 25 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 stesidence 6 Other (Specify) 1 ☐ Yes 200 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA lhis funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK MD 21701 0 CONNER SEVENTH 40 501 4, 31. Date filed (Month Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 06563 1 - State Registra AMEND#8+9perFH2/10/05, BMW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SHAM B. LAL FEB. 7,2005 11:58 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE ,MD MONTGOMERY SHADY GROVE HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) IND A OCT 26, 1925 Funeral Days Hours NONE 1**☆**M 2□F 79 Yrs Director 26, 1925 Usual Residence of Decedent death with the Maryland 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examinar must be notified at Director VA LOUDOUN **ASHBURN** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44157 ALLDERWOOD TERRACE 20147 Itams 23a INDIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, parmil. Pagas 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent if item 27 is marked other then "naturel", or Itan eny injury or pather treumatic event. Its Medical Exerti 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAN/INDIAN Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) AIR FORCE INDIAN GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KARMO DEVI TEHAL RAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NARESH K. SHARMA-SON 44157 ALLDERWOOD TERRACE ASHBURN VA 20147 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State NO. VA CREMATORY 02/09/05 ARLINGTON, VA ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ARLINGTON FUNERAL HOME 3901 N. FAIRFAX DR., ARLINGTON, VA 22203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician FACUMORIO disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** tente Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury burial-transit The law requires that the death certificate be executed Sepsis that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 1 NO 2 No 1 Tyes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Depatient Other: ျ 1 Tes 2 THO 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 061817 Church 3 JEbruary 8, 2005 address of person who completed cause of death (Item 23a) (Type, Print) DR. SHAHYAR M. GHARACHOLOW, MD 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32 egistrar's Signature FEB 1 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 06564 Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Feb 19, 2005 1:50 pm C. Lindner Marguerite 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Allegany Cumberland Devlin Manor Nursing Home If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Dec 15, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Hours 1□M 2□F Yrs. 85 214-12-3536 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1 TyYes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 10301 Christie Road NE Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes Ž☐ No Specify. Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Tyler Arthur Tyler 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 16285 Harwood Dr. SW Frostburg MD 21532 grandson Gary Lindner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/2005 Sunset Memorial Park MD Cumberland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A 21. Signature of Funeral Service Licenses 108 Virginia Avenue; Cumberland, MD 21502 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? †□Yes 3/2Nu 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Physician/Medical Examiner attending physician and for use as the bunal-transit signed by the a à Completed Be ဥ

The law requires that the death certificate be executed certificate has been si rector, page 2 should Hospital or Attending Physicien: director, n 24 hours after death.

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Division of Vital Records, P.O. Box 68760.

Registrar

Certification:

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31. Ageel Saleem) State

27. Manner of Death

1/2 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certified

5 Pending investigation

6 Could not be

30. Name and a dre s of person who comit eted cause of death (Item 23a) (Type, Print)

32. Regignar's Signatur 500 Memorial Avenue Cumberland MD 21502

D0062429

Injury et Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21

29d. Date signed (Month, Day, Year)

105

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Date of Injury (Month, Day Year)

			1 - For State Registrar	State of Ma			ent of F ate of		Mental Hy	giene) ()5	06565
	Physici		1. Decedent's Name (First, Middle, Las Ruth In	^{t)} cene MINEF	2				2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. 0	ity, Town, o	r Location of De	Februa ath	4c. County	2005 of Death	4:50 pm
			Reeders Memorial				Boonst			Wash		
	Funeral Director		217 32 3343	9X 7. Age □M 2☑F	(In yrs. last birth	Mont	hs Days	If Under 24 Hi Hours Min		6, 1914	9. Birthp Cour Mar	place (State or Foreign ntry) yland
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	death with the Maryland ms 23a or 28a-f show I must be notified at	Funeral Director	10e. Street and Number 711 Washington Av	enue		10f.	Zip Code 2]	740		10g. Citizen of V		ntry?
(-)39		by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Exammed Forces? 1 ☐ Yes 2 ☒ Not If Yes, Give Year or Dates:		_	ecedent of H specify Cuba s 28 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	14. Race Blac Specify	k, White,	an Indian, etc. ite
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and	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, I a M	Be	17. Father's Name (First, Middle, Last) William	Ebersole				18. Mother's Na	ame (First, Middle,	Maiden Sumam ae Wolfe		1000
S S	s 1 and 2 should be f Health and Mental fem 27 is marked o othar traumatic eve	To	19a. Informant's Name/Relationship (T		19b. N	Mailing Addr	ess (Street a	and Number or F	Rural Route Numb			0
ZZ,	1 and 2 Health a em 27 is ithar trau		Robert S. Miner	- son					, Boonsb			
	ges 1 and 3 of Health If item 27 or other tr		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removal from State		crematory	or other plac	e)	Date	20c. Location -	•	
7.7.E	permit. Pages Department of Important: If i any injury or one		*4 □Donation 5 □ Other (Specify,)	Mounta			etery 1	Feb 5, 2005	Ringgold	, Maı	ryland
AME; A	permit. Departi		21. Signature of Funeral Service Licens	Randi		415 E	ast Wi	lson Bl		erstown,		yland 21740
8760,	Physician and // // // // // // // // // // // // //	dlcal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Oue to (or as a b. Due to (or as a c.	consequence of)	earde	node of dyin	g, such as cardia	ac or respiratory ai	rest,		Approximate Interval Between Onset and Death
P.O. Box 6	The taw requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death	3 □Ectopie 5 □ Other	pregnancy (specify)			23d. Date Mon		ry Day Year
rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions co	ntributing to death but	not resulting in th	ne underlyin	g cause give	en in Part I.			bute to the	e cause of death?
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Vita	Physician: The this certificate aldirector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		ath (Check only o	ne)		
on of	Jing After fune	lon: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Tim	e of	28c. Injury Work	at	Home 5 ☐ Resid	lence 6 Other)
Divisio	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm (Specify)			/es 2 □No	28f. Location (S City or Tow	itreet and Number n, State)	r or Rural	Route Number,
	Hospita 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of ea and manner state	xamination and/c	eath occurr or investigat	ed at the time on, in my op	e, date and plac sinion, death occ	e, and due to the durred at the time, d	cause(s) and man date and place, ar	ner as sta	ited. the cause(s)
	within To the comple	Me	29b. Signature and title of certifier			:	29c. License	number		29d. Date signed	(Month, D	Pay, Year)
			A. A. Hunder of	MA			D32	518		2/12/05		
_			30. Name and address of person who co									
00/	1-2 Cto		Dr. Robert Gueden 31. Date filed (Month, Day, Year)	et 21 Wya 32. Registrar's	nd Drive	, Ke	edysv	ille, M	21756	301-43	2-222	22
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			1- For State of Maryland / De State of Maryla	epartment of I Certificate of	Health and <i>Death</i>		giene () [06566
	Physici		Decedent's Name (First, Middle, Last) Charles William Milyard		-,-	2. Date of Dea Month Februar	Day	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of De		4c. County of	
			Frederick Memorial Hospital	Frederi			Freder	rick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year Months Days		in. (Month, Day	v. Year)	Birthplace (State or Foreign Country)
	Director		217-56-2028	5.		March 1	1, 1951	Maryland
	yland yland		10a. State 10b. County 10c. City, Town	or Location			-	10d. Inside City Limits
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	iii th	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of Wh	nat Country?
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36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itams 23a or 28a-f ahow aumatic event, it is Medical Evar. It with the Indiffied at	by Funeral	11. Marital Status 1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Marital Status 1. Marital Status 1. Mas Decedent Ever in U.S. Armed Forces? 1. Mas Decede	 Was Decedent of I If Yes, specify Cub Yes 2∑ No 	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black,	- American Indian, , White, etc. White
9	natura	ted	15. Decedent's Education 16a. D	Decedent's Usual Occur	pation		16b. Kind of Busi	iness/industry
215	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done life. DO NOT use retire	during most of word)	vorking		
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and	be fill had had out	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle,)
<u> </u>	should band Ment s markac umatic	^L	John W. Milyard, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. N	Maille Address (Osses	1	len Eyler		
<u>B</u>	d 2 sl th an t7 is r traur		1 1 2 1 1 2	Mailing Address (Street Sherwood				
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once.</u>	1		Disposition (Name of crematory or other pla		ruary 15,		ity or Town, State
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Ba	permi Depa impo any ir		21. Signature Fig. Service Licensee	Resthaven 9501 Catoo	tin Mtn.	. Hwy. Fr	ederick,	Cody P.A. MD 21701
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. PNOMON	I \A				In eek
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ó	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of)):				_
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9	e as t	Med	IF FEMALE:					
O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	
٦.	that t	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ds	w requires that been signed b should be detr	d by	CHRONIC OBSTRUCTURE PULMON		_	15KY	es 2□No 3	Probably 4 Unknown
Records,	s beer	lete	DIABETES			24a. Was a	n 24b We	re autopsy findings available
	The taw cate has page 2 s	Completed				autops perfori	sy prio med? dea	or to completion of cause of ath?
Vital		BeC	SCHIZO PUREN 14 25. Was case referred to medical		26. Place of De	1 ☐ Yes eath (Check only on	/-	Yes 2 No
	Physic this ce al direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.	atient 3 DOA Oth	ner: 4 🗆 Nursing	Home 5 ☐ Reside	ence 6 Other	(Specify)
Division of	ing PI		27. Manner of Death 1/★Natural 5 Pending 28a. Date of Injury 28b. Tim (Month, Day Year) Inju		ry at rk?	28d. Describe ho	ow injury occurred	
<u> </u>	tend leath tor: / the fi	cati	2 Accident investigation		Yes 2 □No			
\leq	or Al after of Dirac in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	spital		29a. Certifier Certifying Physicien: To the best of my knowledge, o	death occurred at the ti	me date and place	ce and due to the co	auso(s) and mann	ar as stated
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/one)	or investigation, in my o	ppinion, death occ	curred at the time, d	ate and place, and	d due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. Licens	se number	2	9d. Date signed (/	Month, Day, Year)
			1/100	D	32171		2/1	2/05
	19		30. Name and address of person who completed cause of death (Item 23a) (Ty					
				PO BON 3	28 4	ALKERS	VILLE M	N 21793
	Sta Registr		31. Date filed (Month Per Sear) 4 2005 32. Restrar's Signature	fresh.				

				For State Registrar			State	of Ma	ırylan			nt of He te of D		nd Me	ental Hy	gier Reg. N	601	05	06567	0
_		Physici		1. Decedent's Nam	•		G. Ma	oV.	orio						2. Date of De Month Februa	eath E	Day	Year	3. Time of Death	 vi
		/Medic Examir		4a. Facility Name (тгте		4b. City	, Town, or	Location of		rebrua		c. County	2005 of Death	3:10 A	_
				Gilchris								owson					Ba	altim	ore	
		Funeral Director		5. Social Security N	7486	6. Sex	M 2XX F		(In yrs. 1. 87	as <i>t birthda</i> y Yrs.) If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di Apr 10	av. Yea	917	9. Birth Cou NOT	olace (State or Foreig ntry) th Carolin	n Na
		fand ow		Usual Residence o 10a. State	10b. County				10c. City	, Town or L	ocation							7.	10d. Inside City Limits	s
		Mary 9-1 sh	tor	MD	Howai	rđ			El	licot	t Cit	.v							1 ☐ Yes 2X No	5
		ith the	Director	10e. Street and Nu	mber		17					p Code		-	- et	10g. (Citizen of	What Cou	ntry?	_
		s 23a	rall	3004 N.	Ridge I					2 1.0		21043					nited			
	36	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28e-f show ont. The Medical Examinating to incitified at	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	_		2. Was Dec Armed F 1 ☐ Yes If Yes, G Year or (orces? 2 📆 ive		5. 13.	If Yes, spe	ocity Cuban	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	D+		ck, White,	can Indian, etc. hite	
	9	72 hou		/Coo.	15. Decedent	's Educ	ation			16a. Deci	edent's Usu	ial Occupa	tion			16b.	Kind of B			-
	Maryland 21215-0036	2 should be filed within 7 and Mental Hygiene. Is marked other then "n eumatic event, the Med	Completed	Elementary/Seco	cify only highes ondary (0-12)	t grade	Completed,		+)	Teac		ork done di use retired)	uring most	of working	9		altin ublic			
	and	ed at b	Be	17. Father's Name		·									First, Middle	, Maide	ən Suman	ne)		
	7	hould id Mer marke	၉	Hayward 19a. Informant's N			ne Print)			19h Mail	ing Address		Lillia		epper Route Numb	as Ca	of Town	Ctata 7i-	- C (-)	_
	Z	s 1 and 2 should f Health and Mer item 27 Is merke other treumatic		Douglas											San Jo				(2009)	
	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		20a. Method of Dis 1 Burial 2 1 Donation	XCremation		emoval from	State		ace of Disp metery, cre				Da -10-2			Location -		own, State	_
	Balti	permit. Departn Importe any inju		21. Signature of Fu	uneral Service L	icensee	with	Ri	M010										ly FH Inc. MD 21043	
10 A M		Physician /Medical Examiner		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	complic only one	_le	U KC	the death e. Miconsequ	Do not er	iter the mo	de of dying	, such as ca	ardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death	
105@3	68760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list co if any, leading to in cause. Enter Unio Cause (Disease or that initiated events resulting in death)	nmediate enlying injury	b. с. d.		11-	consequ											
1/2		certifica nding ph		IF FEMALE:		1			_											
,0	O. Box	ath or i	Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23		birth 2 nant at t	of pregnar 2	death 3	⊒Ectopic p ⊒ Other (s _i						23d. Dat Mo	te of delive nth	ory Day Year	
.3	ls, P.O.	es that I igned by be detar	by	Part II. Other signif	ficant condition	ns conti	ributing to d	leath bu	t not resu	lting in the u	underlying o	cause giver	n in Part I.				_		ne cause of death?	
H	ecords,	> 9 70	ompleted											_	24a. Was	an	24b. \	3 Prob	ably 4 Unknown psy findings available ppletion of cause of	_
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5	Vita	iclan certifii rector	Be	25. Was case refer examiner?		Но	ospital:								Check only o					
2	o	Phys or this oral di	T: To	1 ☐ Yes 2 ☐ 27. Manner of Deat			28a, Date	of Injury	, 1:	R/Outpatie		28c. Injury a	at at		5 Residue 1		6 / the		mospile	_
2	ion	Attending r death. ector: After by the funer	atlo	1/ Natural 2 Accident	5 Pending investigation		(Mon	ith, Day	Year)	Injury	М	Work?	o es 2 □ No			,	,			
20	Division	al or Atte t after de I Directo d in by th	Certification:	3 Suicide 4 Homicide	6 Could no	ot be ned	28e. Place build	of Injui	ry - At hor (Specify)	ne, farm, st	reet, factor	y, office		28	f. Location (S City or Tox	Street a vn, Sta	and Numb (e)	er or Rura	l Route Number,	
MacKenz		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one)	r Certifying 2 Medical E	Physic xamine	cian: To the er: On the b and man	asis of e	examinati	rledge, deat on and/or in	h occurred evestigation	at the time	, date and nion, death	place, an	d due to the at the time,	cause(: date ar	s) and ma	nner as st and due to	ated. the cause(s)	
)	To th withir To th	Me	29b. Signature and	title of certifier		hi	w)			29	c. License	number	<u> </u>			-		Day, Year)	
(2)	0)00	>		30. Name and addr	CIAN	1-46	25 W	V)	660	1 N.	Cha		St a	Bal	hmore					
		Sta Registr	te ar	31. Date filed (Mon	th, Day, Year)	201	05 32. F	agistrar	's Signatu	Ire	besti	0								

			1 - For State RegistraMEND#20b, coerFi	State of Maryla	nd / Depa		t of H	ealth a		ntal Hygi	ene g. No. 200		568
	Dhysia		1. Decedent's Name (First, Middle, Last)						2.	Date of Death	Day Yea	3. Time o	of Death
	Physic /Medi		Barbara Ann Melv	vern					:	Februar	y 6, 200		P M
1	Examir	ner	4a. Facility Name (If not institution, give	•		4b. City,	Town, or	Location of	Death		4c. County of Di		
			Bowie Health Cente		1-45/4-1-1	Bow:		If I lades 2	4 Hen -		Prince (
	Funeral Director		5. Social Security Number 6. Sec. 579-44-5612	7. Age (In yrs. 70	Yrs.	Months		Hours	Min.	Date of Birth (Month, Day, Sept. 2	^{9. E} 7, 1934	Birthplace (State Country) Wash. [or Foreign
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show ta Medical Examinar must be routified at		10a, State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside C	City Limits
	Mar illed	tor	Maryland Prince (Georges Bo	wie							1 🎇 Yes	s 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of What	Country?	
	23a	rai	3800 Evergreen Pa	rkway #110		207	716				United St	ates	
	er de	nne		Was Decedent Ever in L Armed Forces?	J.S. 13. \	Was Deced f Yes, spec	ent of His	spanic Origin, Mexican,	n? (Specifi Puerto Ric	y Yes or No- an, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:				31ack	
21215-0036	d within 72 hours after death with the Maryla jene. ir than "natural", or items 23a or 28a-f show tha Medical Examinar must be collified at	edt	15. Decedent's Educ		16a. Deced	ient's Usua	l Occupa	tion	_	111	6b. Kind of Busines		
212	7 nin 7	Completed	(Specify only highest grade	o completed)	(Give life. L	kind of wor DO NOT us	k done di e retired)	uring most o	of working		DD. Killa of basilles	samuustry	
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Pu	should be filed within the Mental Hygiene. marked other than matic avant, tha Mental Caracter than	Bec	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (F	irst, Middle, Me	eiden Sumame)		
yla	should be ind Mental I	2	James Thompson						Colli				
Maryland	2 m m m	- 3	19a. Informant's Name/Relationship (Ty)	pe, Print)							City or Town, State	, Zip Code)	
d)	1 and Health tem 27 other tr		Andre Thompson /	Son				Gard		_	anham, MD		
Baltimore,	Cor at a to to		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ R	emoval from State Mt	Place of Dispo- cemetery, crep DIVEL	sition (Name natory or ot Cemete	ie or her place CIV) [Date	1 50	c. Location - City of		
Ξ	it. Pa	1	* 4 ☐ Donation 5 ☐ Other (Specify)						2/15/		rentwood,		
Ba	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service License	. 11.	7	Ann c	Address	of Facility	McGui	re Fune	eral Serv Shington,	ice	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pulmonary Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	th. Do not enter Embolise puence of): Thrombo	er the mode	of dying	, such as ca	ardiac or re	espirato <i>r</i> y arres	t,	Approximatinterval Bet Onset and 1 hour	tween Death
Box 68760,	death certificate be executed e attending physician and id for use as the burial-transit	by Physician/Medical Examiner	resulting in death) Last	Due to (or as a consequence of pregnance of Live birth 2 ☐ Feta	ancy	Ectopic pre					23d. Date of d		Year
o.		ysic	1 ☐ Yes 2 ☐No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	eath 5□	Other (spe	crty)				Wichian	Cay	i bai
Records, P.	es bed		Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying ca	use giver	in Part I.			cco use contribute		
CO	> 0 0	lete			-				_	24a. Was an			
	The ate h page	e Completed	25 Was against the adjust							autopsy performe 1 ☐ Yes 2 ☐	d? prior to death?	autopsy findings completion of c	ause of
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ∑Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other			heck only one)			-
	iding Phys	L L	27. Manner of Death	28a. Date of Injury	28b. Time of		c. Injury a	at Nursi			e 6 □Other (Sp.	ecity)	
Ö	Attending r death. ector: After by the fune	atlo	1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury	М	Work?	s 2 No	- 12				
Division	in Site	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, stre	et, factory,	office	121-	28f.	Location (Stree City or Town, S	et and Number or F State)	Rural Route Num	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Certifical Cer	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at estigation, i	t the time in my opir	, date and p nion, death o	occurred a	due to the caus t the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s))
1	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Tol ner	>	29c.	License r	number		29d.	Date signed (Mon	th, Day, Year)	
,	V		MAMAGE	In Indi		D	476	03		Fe	bruary 9	, 2005	
			30. Name and address of person who ber								0.051		
	-64		William DuBoyce 31. Date filed (Month. Day, Year)	32 Magistrar's Signa	0 Mitch		ille	Road,	Bow:	ie, MD	20716		
	Sta Registra	ie ar	31. Date filed (Month, Day, Year) FEB 1 0 200	55 Ethers 1	& An	will							i

State of Maryland / Department of Health and Mental Hygien 06569 1 - For State Registre Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Ruth Marshall Moore February 4:15 p^M 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 409 Old County Road Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 137 F 219-22-9384 Yrs. Director 78 Oct. 2, 1926 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Madical Examiner must be notified at MD Anne Arundel Director Severna Park 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Old County Road or Items 23e 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after of Hygiene. other than "naturel", or Itel 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Pages 1 and 2 should be filed vent of Health and Mental Hygie out; If item 27 is marked other t Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Travers Thompson Gertrude R. Bowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Basil Moore/Husband 409 Old County Road Severna Park, MD 21146 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of H Importent: If ite eny injury or ot once. February 10 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2005 21. Signature of Funeral Service, Licen e 22. Name and Address of Facility Barranco 495 Gov Sons, P.A. tchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final olse or condition ranging in death) METTERISM Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical thet IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) P.0. the 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2[**X**No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only ona within 2. 29b. Sign (Item 23a) (Type, Print) wme and address of d cause of death RU300 PANNAPARS WI BIRATE 4-1-1V 31. Date filed (Month, Day Registrar 0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MILLAN Month Day Year ENDA 09 0130 AM February 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 40101 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 3 F Yrs. 219-57-2413 March 23, 1973 Philippines Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8143 Driver Lane 21144 Philippines

14. Râce - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 □ No 1 Never Married 2 Married 1☐ Yes 2☐ No Specify: 3 Widowed 4 Divorced Filipino 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nurse hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Enriquito Sinato Remedios Bismar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Millan/ husband 8143 Driver Lane Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Crownsville Vet. Cem. Feb. 14, 2005 Crownsville, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St. Annapolis. MD 21401 1// 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): 4 mphoma 24 months disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 26. Place of Death (Check only one) Other: 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Pnysician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is markad othar than "natural", or items 23a or 28a-f show traumatic evant, Ir e Medical Examinar must be notified at

I Hygiene.

Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If itam 27 Is marked other?

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permit. Page:
Department or
Important: If i any injury or once. Ö

death with

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner an/Medical funeral director the Certifical ģ

by Physici	Part
Completed	_
To Be	25.
on:	27.1
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3 🗍 Suicide

29a, Certifier

4 Homicide

(Check only one)

Medical

Hospital or Attanding Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760 attending ph for use as the ed by the a been signe should be After after death. within 24 hours a To tha Funaral D pellij

. Was case referred to medical examiner? 1 □ Yes 2 🕱 No	Hospital: 1 Sinpatient 2 ☐ ER/Outpatient
Manner of Death Natural Accident Manner of Death Death Pending investigation	28a. Date of Injury 28b. Time of Injury

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🚰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier	- 11
MET	ens Mem

D55773

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. WOIFE St. Battimore, MARY AND 21787 -KENNEDY M. BENSEN strar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Floyd Nelson 1:35 A.M February 11, 2005 /Medical 4c. County of Death Prince George's 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Cherry Lane Nursing Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**⊋**M 2□F 74 Yrs. 579-76-0858 <u>Virginia</u> January 15, 1931 Director Usual Residence of Decedent p-mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Cepartment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any highry or other traumatic event. If a Medical Ever in entired the medical and price. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Springdale 1XXYes 2 ☐ No Director Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 U.S.A. 2814 Fox Glove Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ð 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
9th grade College (1-4or 5+) Safeway Stores (Retired) Warehouse Stock Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivory Nelson Josephine Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Chestina Simpson (Sister) 2814 Fox Glove Way Springdale, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State February 18, 2005 Clinton, Maryland Resurrection Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 Approximate Interval Between Onset and Death un. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Artery Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Diabetes Mellitus resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Disease 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No Seizure Disorder 24a. Was an autopsy performed? 2 X No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2X No 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury **⊠**Natural 5 Pending To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19220 February 15, 2005 ne and address of person who completed cause of death (Item 23a) (Type, Print) Neil A. Meade, M.D. 9811 Mallard Drive Laurel, Maryland 20708 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 5 2005 State Registrar

State of Maryland / Department of Health and Mental Hygierie O O S

					Ce	rtificate	e of	Death		Reg	g. No.		Ubu			
	Dhyoisi	an	1. Decedent's Name (First, Middle, Last)					2. Date o			Day Year		3. Time o			
J	Physici /Medic		Catherine Louise Paquette					Februa			y 7, 20			30 pm		
9.	Examin		4a. Facility Name (If not institution, give street and number)							ation of Death	4c. County of Death					
1			Future Care Chesapeake											e Arundel		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependent of Health and Mental Hygiene. Important: If item 27 is marked other than "neturs!, or items 23e or 28e-1 show a birthy or other treumatic event, the Madical Examinar must be notified at once.		5. Social Security Number 016–16–4461	ge (In yrs. last birthday, 96 Yrs.	Months Days Hours Min			Min.	B. Date of Birth (Month, Day, NOV. 27,	9. Birthplace (State or Forei Country) 7, 1908 MA			or Foreign			
Baltimore, Maryland 21215-0020			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10								0d. Inside C	City Limits				
		ctor											2 ⊠ No			
		al Dire	10e. Street and Number 10f. Zip Code 10g 305 College Parkway 21012							g. Citizen of What Country? USA						
		Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:			in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	Blac	14. Race - American Indian, Black, White, etc. Specify: White				
		ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	edent's Usua e kind of wor	l Occup k done	ation during most of	of working	7	6b. Kind of Bu	ısiness/In	dustry			
		nple.	Elementary/Secondary (0-12)	College (1-4or	5+)						ra.,	astic	an.			
		S		4		Teac	ner	_	la Noma /	(Eimt Middle 14		catio		_		
		To Be	17. Father's Name (First, Middle, Last) Joseph Buereau					18. Mother's Name (First, Middle, Maiden Surname) Katherine McLaughlin								
		-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Addrass	(Street	and Number	or Rural	Route Number,	City or Town,	State, Zip	Code)			
			Claire Heath/Dav	ıghter	96	6 Bayb	err	y Cour	t G	reenfie:	ld, MA	0130	1			
			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State cemetery, crematory or other place) 20c. Location - City or Town, State cemetery, crematory or other place) 20c. Location - City or Town, State cemetery, crematory or other place)													
			21. Signature of Juneral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Hor										Home			
75	Physician		23a(Part). Briter the disease, or com	eplications that cause				Ritchie	_		rna Par	rk, N	Approxima Interval Be			
			23al Part 1. Enter the disease, or conshock, or heart failure. List on	one cause on each	ine.			^				į	Onset and	beath Death		
A	/Medical		Immediate Cause (Final disease or condition	PN	EUM	101	11	A				-	16 D	AYC		
	Examiner		resulting in death) Due to (or as e consequence of):													
	.86.790.8	ner										i				
O. Box 68760,	Attanding Physician: The law requires that the death certificate be executed riceath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriel-trensit	by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.													
		Medica	that initiated events resulting in death) Last Due to (or as a consequence of):													
		ian														
		ysic	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying ca	ause gi	ven in Part I.		23b. Did tobacco use contribute to the cause of death?						
P.0		윤	CORONARY ARTERY DISE					LASE	ASE 1 Yes 20 No 3 Probably 4 Unkn					JUNKNOWN		
ds,	sign Id be	d b	CE.UE DE							24a. Was an autopsy 24b. Were autopsy findings			findings			
Ö	w require been si should l	Completed	SENILE BEMENTIA							performed? available prior to completion of cause of death?						
Division of Vital Records,	in: The lav ificate has or, page 2	mc.								1 □ Yes	s 2000	11	□Yes 2□	□No		
			25. Was case referred to medical					26. Place	of Death	(Check only one						
	/sicie s cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ 10	Hospital:	ient 2 ☐ ER/Outpatie	ent 3 DC	OA Ot	her:		e 5 Resider		er (Speci	fy)			
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2:	n: T	27. Manner of Death	28a. Date of In (Month, D			8c. Inju	ry at	2	8d. Describe hor	w injury occur	red				
0		atio	1 DNatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No													
V:		titic	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Ö		Cer	Durang, etc. (cpt sty)													
		edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
	ithin (N N	one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
	h• ≷ h• Q		> Houptingh MD D14160 FEBRUARY 07,2005													
			30. Maine and address of person who combined cause of death (Item 23a) Type (Print) Sylo-A RITCHIE HIGH WAY BALTIMORE, MD. 2(22)													
	Sta		31. Date filed (Month, Day, Year)	32. Refts	trar's Signature	Louis	6,				_					
	Regist	rar	150 1	2001	and the	7	ALE									

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			1 - Stata 3-8-05 tas 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.	No.	
	Physici		Matthew Thomas Quinn			Day 202, Year 5	3. Time of Death 2:30 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 obligation	4c. County of Death	2.30 1
j	·		Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Frederick inthday) If Under 1 Year If Under 24 Hrs.	O Date of Dist	Frederic	
17	Funeral Director		214-98-5965 ¹₹ ^{M 2□} F 38	Yrs. Months Days Hours Min.	8. Date of Birth Month, Day Ye Jan • 19,	^{9. B} 1967 Mar	lace (State or Foreign Yland
/-	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow			1	Od. Inside City Limits
	Ba-f sh	Director		derick			1 ☐ Yes 2 ☐ No
**	hours after death with the Maryland ural, or Hems 23a or 28a-f show al Extentional be mullibed at	al Dire	10e. Street and Number 4981 Pintail Court	10f. Zip Code 21703	10g.	Citizen of What Coun U.S.A.	try?
	tems z	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036	ours after de ral', or ttems Exs. cirat is	b	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: Whit	
15-0	"netur	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ing 16t	o. Kind of Business/Ind	lustry
212	withir piene. r than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 2	Writer		Writing	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "netural", or eny injury or other treumetic event, Ita Medical Extensione.	To Be C	17. Father's Name (First, Middle, Last) Philip T. Quinn	18. Mother's Name Dian	e (First, Middle, Mail e Fields	den Sumame)	
	ind 2 shou alth and M 27 ie mai or treumei		19a. Informant's Name/Relationship (Type, Print) Philip T. Quinn, father 45	b. Mailing Address (Street and Number or Rura 981 Pintail Ct., Fred	erick, MD	ity or Town, State, Zip 21703	Code)
Baltimore,	Pages 1 a nent of He nnt: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of cemete Nount C	ory crematory or other place)		Location - City or To Frederick	
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service License M00255	Keeney and Basfore 106 East Church St	d PA Fune	ral Home	1701
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between
	Physician /Medical			phine and darvocet)int	oxication	1	Onset and Death
	Examiner		Due to (or as a consequence	ot):			
	pa sit	iner	Sequentially list conditions, if my feat the cause. Enter Undertying Cause (Disease or injury	al):			
ó	be execute sician and burial-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):			
8760,	cate be physicia the bu	dical	d				
Вох 68	certifica nding pt use as th	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	_		23d. Date of deliver	v
o.	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Day Year
0	requires that the een signed by th nould be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in		23e. Did tobacc	co use contribute to th	e cause of death?
ord	w require been sig should b	eted	Hypertensive atherosclerotic cardio	vascular disease,	1 🗆 Yes	2 No 3 Proba	ably 4 Nunknown
Records,	sicien: The law certificate has t irector, page 2 s	Completed	schizophrenia		24a. Was an autopsy performed	prior to con	sy findings available pletion of cause of
Vital	ien: T rtificati	a	25. Was case referred to medical	26. Place of Death	(Check only one)	No Yes	2 No
of V	Physicien: this certific ral director,	To B	examiner? 1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 X ER/OL	utpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence	6 ☐ Other (Specify	
ouo	ling After fune	tion:	1 Natural 5 Pending 2-19005 Pearl 2:0	Time of 28c. Injury at 2	28d. Describe how in	njury occurred unk	
Division	r Attending I er death. rector: After by the funer	Certification:	2 Accident 3 Suicide 4 Homicide 6 XCould not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	uu p	28f. Location (Street	and Number or Rural	Route Number,
Ö	urs afte	Cer	found athome		rederick,	Maryland	tail Court
	To the Hospital or Attend within 24 hours after death To the Funerel Director; completely filled in by the	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge 2 ☑ Medicel Examiner: On the basis of examination an and manner stated.	 death occurred at the time, date and place, a id/or investigation, in my opinion, death occurred 	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Pay, Year)
)) M. Jit	OCME	Fe	bruary 21,	2005
			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) 111 Penn Stree	t Baltim	ore. Marvl	and 21201
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature			,	
3	🦼 . Registr	ar	FEB 2 8 2005 Brown D.				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 910 **Physician** RUKHOVETS Felo 2005 REYZA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY ROCKVILLE HEBREW HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | NOV EMBER 8, 1904 9. Birthplace (Stete or Foreign Country) 4. RUSSIA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 💢 F 100 Yrs. 104-76-7222 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example maritimet must be institlied at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No SILVER SPRING Director MD MONTGOMERY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? NONE 11700 OLD COLUMBIA PIKE APT. 718 20904 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: à WHITE 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be YOSELEVSKY **GUTA** UNKNOWN 10 SAMUIL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 57 RICHARD ST. TENAFLY, NEW JERSEY 07670 ROBERT B. RUKOVETS - GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/13/2005 ISELIN, NEW JERSEY MT. LEBANON CEMETERY 21. Signatore of Emeral Service Ligense 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
II800 NEW MAMPSHIRE AVE. SILVER SPRING, MD 20904 7 23a. P.m.1. Enter the disease, or complication that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a herosclastic cordio vascular **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exan iner Due to (or as a consequence of): attending physician for use as the buria Physiclan/Medical Вох IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe 3 Probably 4 □thknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 100 Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2₽No of funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After or Attending Division 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Funeral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after To the Hospitel 💶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P:44907 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PONSUEL Road Rockculte 6105 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2005 Registrar

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	Physic /Medi			Á.	Rodenl	nauser			2	2. Date of D		Day -2	Year S		ne of Death 35 A M
	Exami	ner	4a. Facility Name (If not institution, git 14114 Royal Oak 5. Social Security Number 6.	Dr. SW	er) Age (In yrs. last birthda	Cres	apto	Location of DWN If Under 24		8. Date of Bi		4c. Cour Alle			
	Funeral Director			1□ M 2□ X F	72 Yrs.		Days	Hours	Min.	B. Date of Bi (Month, D May 8	av. Yea	932	9. Birth	ntry)	ate or Foreigr
	e-f show	ctor	MD 10b. County Allega	any	10c. City, Town or Cre	Location Saptwor	1						1		le City Limits Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 14114 Royal Oak	Drive SW		10f. Zip C		21502			10g. (f What Cour	ntry?	
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28e-f show or other treumatic event, the Medical Examination in colling at	b	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give 'Year or Dates	₹ _{No}	. Was Decede If Yes, specifi 1 \(\text{Yes} \) 2[spanic Origin, Mexican, I	n? (Speci Puerto Ri	ify Yes or Nican, etc.)	0-	14. Ri Bi	ace - Americ lack, White,	etc.	٦,
Maryland 21215-0036	filed within 72 h Hygiene. other then "natu ant, the Medical	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4o	r 5+)	edent's Usual re kind of work DO NOT use Duter De	done du retired)	uring most o	of working	7			Business/In		Γire
yland	should be fill and Mental Hi is marked oth	To Be	17. Father's Name (First, Middle, Las Samuel A. Nich	nolson						First, Middle na Sh			,	on	
	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship Jane Nicholson	Турө, Print) Siste	er 19b. Ma	ling Address (i Memori	Street ar	nd Number Venue	or Rural F	Route Numb					21502
imore	Ly and Pa		20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special Content of the Conten	Removal from Stat	20b. Place of Disposer Sunset Me	ematory or oth	er place)	Dat 2	te /23/2005			erland		MD
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	nsee A	M	22. Name and SCA 108	Address rpelli Virgi	Funera	al Hon	ne, P.A Cumbe					
	nysician /Medical Examiner		23a. Part1. Enter the disease, or con shock or hear failure. List only limediate Cause (Final disease or condition resulting in death)	a	ed the death. Do not e line. The line will be the line with the line will be the line will	nter the mode	of dying,	such as ca	urdiac or r	respiratory a	rrest,	u, IVIL	F2-15U2	Approxir Interval	mate Between nd Death
8760,	cate be executed physicien and the burial-transit	dlcal Examiner	Sequentially list conditions, Tary, team growth and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	s a consequence of):										
Box 6	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic preg □ Other <i>(spec</i>							ate of delive	ry Day	Year
rds, P	igned be de	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cau	se given	in Part I.					ntribute to th		
I Rec	ine iaw ate has b page 2 si	e Completed	25. Was case referred to medical							1 Yes	osy ormed? 2 N	,	Were autop prior to con death? 1 \(\subseteq \text{Yes} \)	npletion o	gs available if cause of
	After this funeral dir	ertification; To Be	25. Was case referred to medical examiner? 1 Yes	Hospital: 1 Inpat 28a. Date of Inj (Month, D	ury 28b. Time		Other: Injury a Work?	4 □ Nursii	ng Home	Check only of Residue 1. Describe l	dence		her <i>(Specify</i>)	
	s effer deat I Director: ed in by the	Certific	3 Suicide 6 Could not be determined	28e. Place of In	njury - At home, farm, s rtc. (Specify)	reet, factory, o	ffice		28t.	Location (5 City or Tox	Street a vn, Stai	ind Numi te)	ber or Rural	Route N	umber,
	within 24 hours effer death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysicien: To the best niner: On the basis and manner s	t of my knowledge, dea of examination and/or in tated.	th occurred at investigation, in	the time, my opin	, date and p nion, death o	lace, and	due to the at the time,	cause(: date ar	s) and m	anner as sta and due to	ited. the cause	9(s)
1	within 2 To the complet	Me	29b. Signature and title of certifier	en,			D0	number 06242	29		29d. Da	ate signe	od (Month, D	ay, Year,)
	Sta Registr		30. Name and address of person who Ageel Saleem 31. Date filed (Month, Day, Year) FEB 2 8 20	32 Regist		Print) Memoria	al Av	enue/	Cum	berlar	nd N	4D 2	1502		

			1 - For State Registrar		State of	Maryla		artment <i>rtificate</i>				ental Hy	/gien Reg. N	ZUU:	5 0	6576
	Dhusisi		1. Decedent's Nan	ne (First, Middle, I	ast)							2. Date of D Month		ay Yea		. Time of Death
	Physici /Medio		Ok	Soon	Shin							ebrua		12,05		3.09AM ^M
	Examir				ive street and numb			4b. City, To					4	c. County of De		J 4-10 J 1 1 1
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	Director		224 45		1 M 2 F		75 Yrs.				1	pril	4,	1929	S.	Korea
	and		Usual Residence of 10a. State	10b. County		10c. C	Sity, Town or Lo	cation							10d I	Inside City Limits
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	the 28a	Director	10e. Street and Nu		mer y	Bu.	rtonsv	10f. Zip C	ode				10a C	itizen of What		21
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	Jeath Tra 2:	Funeral	11. Marital Status		12. Was Decede	ent Ever in U	J.S. 13.	Was Deceder	nt of Hi	spanic Orio	nin? (Spe	city Yes or N		rea 14. Race - Ar	nerican I	ndian
Maryland 21215-0036	hin 72 hours after death with the Maryland B. In "natural", or Itema 23a or 28a-f show Medical Examinar must be notified at	þ	1 Never Mar	ried 2 Married	Armed Force	es? ∏No X		If Yes, specify 1 ☐ Yes 24	/ Cubai	Specify:	, Puèrto i	Rican, etc.)		Black, W.	hite, etc.	,
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ם	be filed ital Hygi od othar avant, t	Be (17. Father's Name		,					18. Mothe	r's Name	(First, Middle				
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lan	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's N	lame/Relationship	(Type, Print)		19b. Mailir	ng Address (S	Street a	nd Numbe	r or Rura	l Route Numb	er, City	or Town, State	, Zip Cod	20878
	and salth n 27		David C	Shin (Brother))	9/0	4 Wasi	$_{11}$	aton	B1	vd. G	ait	hersbu	ma l	20878 Md
Saltimore,	oth oth		20a. Method of Dis	sposition	☐Removal from St	20b.	Place of Dispo cemetery, crer	sition (Name	of	-		ate	20c. L	ocation - City	or Town,	State
Ĕ	Pages nent of ant: If it ury or o			5 Other Spec	ify) NO1	beck	Memo	rial :	Par	k	2/1	5/05	01:	nev M	F-1	
alt	Department (Department (Important: If any injury or once.		21. Signature of	ineral Service Lic	nsee)	22	. Name and	Addres	s of Facility	V					
<u> </u>	#2E # 9			911	mx			2303	_V a	sza k	Cna:	ries .	Hind	ds Fur	era.	l Serv.
			23a. Part1. Enter shock, or hea	the disease, or co art failure. List on	mplications that cau by one cause on eac	sed the dea h line.	th. Do not ent	er the mode of	of dying	such as	cardiac o	r respiratory a	errest,	Maribo	Ap Inte	ate erval Between
	Physician		Immediate Cause disease or conditi	on	Seps	sis									Ons	set and Death Years
	/Medical Examiner		resulting in death)		Due to (or	as a conse	quence of):									rears
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387	ficate phys s the	edical			d										 	
	ding se as		IF FEMALE:		23c. If yes, outco	me of oregon	ancy									
Вох	death cert e attendin id for use	Physician/M	23b. Was deceder in the past 12	months?	1☐Live birth	n 2 ☐ Feta	al death 3	Ectopic preg						23d. Date of d Month	elivery Day	Year
	the d y the ched	iysle	1 □ Yes 2x 9 □ Unknown	No	9□ Unknow		Jean 5_	TOTTIET (Speci	'y)							
σ.	that hed by deta	P	Part II. Other signi	ficant conditions	contributing to deat	h but not re:	sulting in the ur	nderlying caus	se give	n in Part I.		23e. Did 1	tobacco	use contribute	to the car	use of death?
ds	The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	d by							•			1 🗆	Yes 2	□No 3□!	Probably	4 Unknown
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Vital Record	e la has	Completed										24a. Was auto		prior to death?	o complet	indings available tion of cause of
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⋚	sicia certi irecto	o Be	25. Was case reference examiner?		Hospital:		7.500		Other			(Check only o		-		
of	Phy rthis rald	\vdash	1 Yes 2X		1 Xinp 28a. Date of I		ER/Outpatien 28b. Time of		1	4 LI Nur	7.	ie 5 □ Resi 8d. Describe		6 □Other (Sp	ecify)	
OU	ding th: Afte fune	ţ.	1 XNaturai 2 ☐ Accident	5 Pending investigate	(Month,	Day Year)	Injury	М	Injury Work	? es 2□N		00. 00001100	now inju	ry occurred		
Division	Attanding Physician: r death. ector: After this certific by the funeral director.	fica	3 🗌 Suicide	6 Could not	be go Disco of	Injury - At h	ome, farm, stre			00 2		8f. Location /	Street ar	nd Number or F	Rural Roy	ite Number
\leq	after Direct	Certification:	4 Homicide	determine	building,	etc. (Speci	fy)	oct, ractory, o	11100		-	City or To	wn, State	9)	ibiai i iot	ne i variber,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier	Certifying P	hysician: To the be	st of my kno	owledge, death	occurred at t	the time	e, date and	place. a	nd due to the	causeis) and manner	is stated	
	ne Ho na Fu	edical	(Check only one)	☐ Medical Example 1 ☐ Medical Example 2 ☐ Medical Example 2 ☐ Medical Example 3 ☐	miner: On the basi and manner	s of examina	ation and/or inv	restigation, in	my opi	nion, death	occurre	d at the time,	date and	d place, and du	e to the	cause(s)
	To th To th comp	Me	29b. Signature and	title-of certifier	1.0		, -	29c. L	icense	number			29d. Da	te signed (Mor	th. Day,	Year)
			► KA	CUTTE	Meles	1000	(ell)	7+ D	00	561	53		2/	12/05		
	(2)		30. Name and addi	ress of person who	completed cause of	of death (Iter	m 23a) (Type.			201			,	, , , ,		
					Md, 3110				đ.	Silv	er	Sprin	or M.	d 209	n 4	
	Sta	te	31. Date filed (Mon		≆ 2. Regi	strar's Signa		ماد				T	<i></i>			
	Registra	=1	FE	D → ♥ /(IL		- 4	- August	JE 3								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. TT State of Maryland / Department of Health and Mental Hygien Sheryl Ann Rita Samuel 05-1229 06577 For State Registrar AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Vasi **Physician** Sheryl Ann Samuel February 16, 2005 2:55 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 6415 Fairbanks Street Hyattsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 12,1960 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday. 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖸 F 213-96-2965 Director Trinidad 44 Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28e-f ehow other treumatic event, the Madical Examiner plust be notified at TYes 2 □ No Director MD Prince Georges New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 6415 Fairbanks St. or iteme 23a 20784 Trinidad deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status a filed within 72 hours after de I Hygiene. other than "natural", or Item Black, White, etc. ☐Yes 2☐No Yes. Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other treumatic event, Instance. 12thRestaurant Self-Empolyed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Trevor Raphel Marlene Samuel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shurla Samuel/Sister 11175 Columbia Pike Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) George Washington Ce. Feb. 21, 2005 Adelphi, MD 21. Signature of Funeral Service I censee 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part / Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): ettending physicien for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the deteched 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No 2 No 1 Yes Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: $_4\square$ Nursing Home $_5\square$ Residence $_6$ Ω Other (Specify) at scene 1XXYes 2 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1X Natural 5 Pending investigation 1 Yes 2 No death. М 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier February 16, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 2 3 2005

2. Registrar's Signature 2. Registrar's Signat

21201

State of Maryland / Department of Health and Mental Hygiene | 15 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Month 23 PM **Physician** 14,2003 Shrader, Jr. ebrua William Brenton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 2, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F Months 78 Director 219-20-1014 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other treumatic event, the Medical Exerting Light Le notified at 1 ☐ Yes 2 🔯 No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20009 Rosebank Way 21742 238 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or Itams 23a any njury or other treumatic event, The Medical Exert methods. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 0 / / 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No 1944-If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Signal Dept. City Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charolette Bikle William B. Shrader, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20009 Rosebank Way, Hagerstown, MD 21742 Norma L. Shrader/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/18/2005 Rest Haven Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rest Haven Funeral Chapel S-Mark Su 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or combilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 16 hor Physician Circulations disease or condition resulting in death) /Medical Due to (or as a consequence of): 24 hor Examiner 50 151 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached signed by the 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 PNo 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 41667 Michael 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MECGmedical neil(31. Date filed (Month, Pay, Year) 32. Begistrar's Signature State 10 Registrar

State of Maryland / Department of Health and Mental Hygiene 06579 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Margaretha Swoope Feb. 9, 2005 10:10a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy 2927 Greenvale Road Chase Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth **Funeral** 1 M 2 KF 870671911 93 Director Delaware 178-30-2585 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any jury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Chevy Chase MD Montgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 2927 Greenvale Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anne Porter James Milliken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coal 0815 2927 Greenvale Road Chevy Chase, MD Anne Swoope Feinberg/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Remoyal from State Oak Hill 2/12/05 Curwensville, PA. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ameral Service Ligens PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit 15 yrs Multi-infarct dementia and Due to (or as a consequence of) Box 68760 physician Atherosclerotic cardiovascular disease Physician/Medical the use as attending 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 0 Month Day Year 4 Pregnant at time of death 5 Other (specify) detached i Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ signed l d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performe certificate 1 Yes 2 X No 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 Feb. 9, 2005 30. Name and address of person who competed case of death (Item 23a) (Type, Print) Susan J.Miller MD 6844 Tulip Hill Terrace Bethesda, Md 20816 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State 10 Registrar

Division of Vital Records, P.O. Box 68760.

				Please '	Type or Pri					-		-	
		•	For State Registrar		State of M	aryland /		rtment of F tificate of		ı Mental H	ygiene Reg. No.	2005	06580
Phys	sicia	,	1. Decedent's Name (i		-					2. Date of D _Month	eath Day	Year	3. Time of Death
	dica		Marie Sa							Febru	ary 1	1 2005	2:15 a ^M
Exa	mine	er	4a. Facility Name (If no)		4b. City, Town, o		ath	4c.	County of Death Carrol1	
Funer	101		Carroll F 5. Social Security Num			ge (In yrs. last	birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of B	irth	9 Birtho	
Direct			216-24-162	25	□ M 2 1 F	86	Yrs.	Months Days	Hours M	in. (Month, E March	8 19	18 Coun	lace (State or Foreign stry) NC
pu »			Usual Residence of De	ecedent 0b. County		10c. City, T	oum or Lo	nation					Od In-id- City ti-it-
faryla shov		٥	MD	Carro.	11								0d. Inside City Limits 1 ☐ Yes 2 XNo
the N 28e-1		Director	10e. Street and Number		<u></u>	VVE	SOUIL	nster			10a. Citiz	zen of What Cour	stry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. It filem 27 is marked other then "neturel", or Items 23e or 28e-1 show or other then the Earling or Items 200 to 20			4139 Tur	key Foo	t Road				158			USA	,.
deati		Funerai	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cubi	lispanic Origin?	(Specify Yes or N	10~ 1	14. Race - Amend Black, White,	
or Ite			1 Never Married	1	1 ∐Yes 2.X If Yes, Give	No		☐ Yes 2☐ X so	Specify:	ono modn, etc.,		Specify: Whi	
hours fure		ed by	3X Widowed 4 [5. Decedent's Ed	Year or Dates:		Sa Docad	lent's Usual Occup	ation			nd of Business/Ind	
nin 72		Completed		only highest grad	de completed)		(Give	kind of work done OO NOT use retire	during most of v	vorking	100. Kii	id of Dasifiess/file	dustry
2 should be filed within and Mental Hygiene. Is marked other then eumetic event, Italia.		E O	5	ary (0-12)	College (1-4or	5+)		Homemak	er		(Own Home	
al Hy d other		Be	17. Father's Name (Fin	rst, Middle, Last)						lame (First, Middl		Sumame)	
y ca ould the Ment Ment Ment Ment Ment Ment Ment Men		ဝ	(unknown							(unknown)			
VICE 12 sh h and 7 is m treum			19a. Informant's Name			1 1		g Address (Street					Code)
T, IN 1 and Health em 27		-	Alice Cro		iter	20b. Place	of Dispos	Turkey I		ad Westn Date		eation - City or To	21158 wn. State
Pages nent of H int: If ite				Cremation 3 🗍	Removal from State	'		natory`or other plac	2/3	l2/2005			ille, MD
permit. Pag Department Importent: eny injury o	, pj	Ì	21. Signatur 1 Fu	110		Cres		n Memoria Pitts fu					1110, 110
	SUCE		>14 ast	Vels			4.	12 Washir	naton Ro	and West	minst	er. MD	21157
			23a. Part1. Enter the shock, or beart f	disease, or comp ailure. List only o	lications that cause one cause on each	d the death. E	o not ente	er the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between
Physicia			Immediate Cause (Fir disease or condition	nal	· ACIT	EAH	KTE	RIDR	(1) AL	I INI	FARC	MOIT	Onset and Death
/Medic Examin			resulting in death)		Due to (or as	s a consequen		1101	W •		-1.71 1/2		- (-
		-	Sequentially list condition if any, leading to imme	itions, ediate	Due to (or as	s a consequen	ce of):						
uted J ansit	-	Examiner	cause. Enter Underly Cause (Disease or inju- that initiated events	ing ury	,								
be executed sician and burial-transit			resulting in death) Las	st	c. Due to (or as	s a consequen	ce of):						
ate be nysicia he bu		cai			d			-					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Physician/Medicai	IF FEMALE:		00 11	,							
attend for us		ian/	23b. Was decedent pring the past 12 pro	regnant		2 Fetal de	ath 3 🗆	Ectopic pregnancy	,		2	3d. Date of delive Month	ry Day Year
the de	- -	ysic	1 □ Yes 2 7 9 □ Unknown	40	4⊡Pregnant a 9⊡ Unknown	ii time or death	1 5L	Other (specify)					
that hed by deta	li	by Ph	Part II. Other significa	ant conditions co	ontributing to death	but not resultin	g in the ur	iderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
quires en sign uld be		g pa	HYPER	CAL	CEMI	A				1 🗆	Yes 2	No 3□Prob	ably 4 Unknown
le law re has bee		Completed	RENAL	- FAI	LYRE	_				24a. Wa	s an	24b. Were autop	osy findings available
The ate has page		E	CHRON	10 DE	STRU	CTIL	FI	LING T	140A	Q D 1 □ Yes	ormed?	death?	2 No
icien: Th certificate rector, pag		Be (25. Was case referred examiner?	-						eath (Check only	оле)		
Physi this o		2	1 ☐ Yes 2 No 27. Manner of Death	2	Hospital: 1 Mopati 28a. Date of Inj			3 DOA Oth	4 Nursing	Home 5 Res)
ding h. After tuner		ion	1 Natural	5 Pending investigation	(Month, Da	ay Year)	o. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	now injury	occurred	
Atten r deat sctor: y the		fica		6 Could not be determined	286. Place of Ir	jury - At home	, farm, stre	eet, factory, office		28f. Location	(Street and	Number or Rura	l Route Number,
s after		Certification:	4 Homicide		building, e	tc. (Specify)				City or To	wn, State)		
To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the tuneral director, page 2.			29a. Certifier 1 (Check only 2	Certifying Phy	sicien: To the best	of my knowled	dge, death	occurred at the tir	ne, date and pla	ce, and due to the	cause(s)	and manner as st	ated.
the H nin 24 the F		Medicai	one)		and manner s	tated.				Culted at the time			
5 til o		Σ	29b. Signature and titl	or certifier		. \		29c. Licens	e uniidet		29d. Date	signed (Month, I	Jay, Year)
NIL		-	30 Name 200	SN	completed as in	death (tram on	a) /Turn !) 2 Print)	505	2		1100	MD
4			30. Name and address	S OLDERSON WILD O	completed causion	M NO	a) (Type, I	orint) 31 104306	ATIE	DDIVE	OW	1165	21117
	Stat	е	31. Date filed (Month,	Day, Year)	32. Regist	rar's Signature	ال	UJJRC	9 1 <i>72</i> .	VKIVE	1 141		
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			1 - State Registrar			Cei	rtificate	e of L	Death		Ra	g. No.	UU	06581
	Physicia	an	1. Decedent's Name (First, Middle,	Last)						2	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		Bruce David								'ebruary			2153 ^M
	Examin	er	4a. Facility Name (If not institution,		iber)				Location of				ity of Death	
			5. Social Security Number		7. Age (In yrs.	last birthday)			nster If Under		. Date of Birth		rroll	
	Funeral Director		213-36-8091	1 ∑ M 2□F	64_	Yrs.	Months	Days	Hours	Min.	(Month, Day, lar 13,			hplace (State or Foreign untry) Yland
	D		Usual Residence of Decedent								OI 1. 2 p	1940		-
	arylar ehow	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	Director	Maryland Carro	L1		West	tmins				T 40			
	with the or 3	Ö		- 1			10f. Zip		1		10	g. Citizen o	r What Cor	untry?
	ns 23	Funeral	2714 Coon Clu	12. Was Dece	dent Ever in U	I.S. 13. V	Was Deced		157 spanic Ori	gin? (Speci	fy Yes or No- can, etc.)	USA 14. R	ace - Amer	rican Indian,
ပ္	after o	Fur	1 ☐ Never Married 2 ☐ Marrie	Armed For	2 -No	i					can, etc.)	Bi	lack, White	
Ö	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da			1□Yes 2	ZINO	Specify:			Spec		White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f ehow int, it a Madical Examirer must be notified at	Completed	15. Decedent's (Specify only highest			16a. Deced	dent's Usua kind of wor	l Occupa	ation Juring most	t of working	1	6b. Kind of	Business/l	Industry
12	within ane. then	ш	Elementary/Secondary (0-12)	College (1-	4or 5+)									i
	filled Hygid Sther	ပိ	12 17. Father's Name (First, Middle, La	ost)		HVAC	Techi	nici		er's Name (i	First, Middle, M		Meade	3
lan	ld be ental ked c	To Be	William E. Stif	f					Mil	dred	J. Webe	r	,	
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Number,		n, State, Z	ip Code)
	and 2 salth a n 27 li		Janice E. Stiff	Wife		2714	Coon	Clu	b Rd.	Wes	tminste	r, MD	211	.57
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from S	20b. F	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place	θ)	Dat	ie 2	0c. Location	- City or T	Town, State
Ĕ	. Pages Iment of I Ient: If ite		`4 □ Donation 5 □ Other (Spe			. Paul			ry	2/11/	2005 U	niont	own,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then. Insturat, or Items 23e or 28a-f ehow entry figury or other treumatic event. It is Mudical Examination and the notified at ODEs.		21. Signature of Funeral Service Li	censee 1										Chapel, PA
_	45204		23a. Part1. Enter the disease, or co	mplications that ca	used the deat		12 Was				Westmin	· · ·		21157 Approximate
Ь	Marion.		shock, or heart failure. List or Immediate Cause (Final	nly one case on ea	ch line.	an. Do not ant	er me mou	e or ayırıç	y, such as	Cardiac or i	espiratory arres	»l,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. 17.50	or as a conseq	ulanaa ofi:							- 1	Minutes
P	Examiner				7 43 4 001136Q	juditice (i).								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (d	or as a conseq	uence of):								
	acutec ind transi	Examiner	that initiated events resulting in death) Last	с										
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		resulting in death) cast	Due to (d	or as a conseq	luence of):								
687		dical		d							_	<u>.</u> .		
×	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								23d, D	ate of deliv	varv
Box	death a atter	iclar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	th 2∏Feta int at time of d		Ectopic pro Other (sp						fonth	Day Year
0	t the by the lache	hys	9 Unknown	9□ Unkno	wn									
s, P	S L O	by Physiclan/Med	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did toba	icco use co	ntribute to	the cause of death?
ord	w require been sig should b	ted									1 🗆 Yes	2 □ No	3 2 Pro	bbably 4 Dunknown
ec	has b	Completed									24a. Was an autopsy		prior to co	opsy findings available ompletion of cause of
E H	: The licate hat, page			· , · · · · · · · · · · · · · · · · · ·							perform 1 Yes 2	No	death?	2 🗆 No
Vital Record	ysicien: Th is certificate director, pag	Be c	25. Was case referred to medical examiner?	Hospital:		6-a-a : :	-7	Othe			Check only one			
	Physical di	: To	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury	ER/Outpatien 28b. Time of	_	8c. Injury	4 LI NU		5 Resident			ify)
ion	nding tth. r: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investiga	(Month	, Day Year)	Injury	М	Work	:? /es 2 □ t	No				
Division of	afer death. after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place	of Injury - At ho	ome, farm, str	eet, factory	, office		281	f. Location (Stre City or Town,	et and Nurr	ber or Rui	ral Route Number,
	rs afton	Cer			g, oto. (opcom						0.19 0			
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Madical Ex	Physician: To the laminar: On the ba	sis of examina	wledge, death ition and/or inv	occurred a	at the tim	e, date and pinion, deat	d place, and th occurred	d due to the cau at the time, dat	se(s) and n	anner as	stated. to the cause(s)
	thin 2 the the mplet	Med	29b. Signature and title of certifier	and mann	er stated.				number					, Day, Year)
ı	F 3 F 8	-		1	2	VX	250			COLL		_		
	Wis		30. Name and address of person w	no completed cause	of death (Item	1 () n 23a) (Tyne	Print)	IVC	ノレウト	429	1-4	ehrua	147	12007
			He het ! F	en la	C S.I La		h17	24	73 IA	Nanc	leyte	R.1	Man	12005 whester MD
	Sta		31. Date filed (Month, Day, Year) FEB 1	32. Re	gir rar's Signa	ature			V		- / - /			
	Registr	ar	LEDI	0 2005	Geneva	N.	Spark	2						

		1	For State Registrar	State of Maryla		artment of F			Reg. No.	06582
	/sicia	n	1. Decedent's Name (First, Middle, Last) Troy Ly	'nn	Shoema	ker	Ш	2. Date of De Month FEBRUA	Day	3. Time of Death 2005 8:45a
Exa	amine		ta. Facility Name (If not institution, give s MEMORIAL HOSPITAL			CUMBERLA			4c. Count	ANY
Fune Direc			5. Social Security Number 217-02-1342 Usual Residence of Decedent	M 2□F 21	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da Apr 5,	1983	9. Birthplace (State or Foreign
Maryland	le del		10a. State 10b. County Allegan	y 10c.	City, Town or Lo Creas	cation saptown				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the	Non ag 18	ਰ∣	10e. Street and Number 14404 Spruce Sprii	ngs Road		10f. Zip Code	21502		10g. Citizen of	What Country?
21215-0036 Within 72 hours after death with the Maryland liene. Then "natural" or Items 23a or 28a-f show	EXAMINET ON	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puen Specify:	pecify Yes or No to Rican, etc.)		ce - American Indian, ick, White, etc. ^{fy:} White
within she.	I'le Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o OO NOT use retired an	during most of wor	rking		dusiness/Industry
be filed that Hyg	event.	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Troy Lynn Shoen	naker				ne <i>(First, Middl</i> e, Deanna		ell Shoemaker
Te, Maryla 1 and 2 should Health and Men tem 27 is marke	or other traumatic		19a_Informant's Name/Relationship (Type Troy Shoemaker	father	19b, Mailin 144(g Address (Street a	Springs F	Rd Cresa	er, <i>City</i> or Town aptown	MD 21502
Baltimore, permit. Pages 1 ar Department of Hea Important: If item	iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State R	p. Place of Dispo cernetery, cren estlawn M	sition (Name of natory or other place emorial Gar	dens	Date 2/24/2005		City or Town, State
Baltimo	any inju		21. Signature of Funeral Service Licens	Anna	7	Nam Starpen 108 Virg	ที ศีน์ที่⊎ีYal H jinia Avenu		rland, MD	21502
ificate be executed Examin By physician and Phys	cal ner	edical Examiner	23a. Part. In the disease, or complications, shock, br heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	er the mode of dyin				Approximate Interval Between Onset and Death
Geath certif	or use a	₹I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy				ite of delivery onth Day Year
0 8 B	90 90	by P	Part II. Other significant conditions con	tributing to death but not r	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	1/	tribute to the cause of death?
The law ate has b	page	e Completed	25. Was case referred to medical					1 Yes	osy rmed? 2 □ No	Were autopsy findings available prior to completion of cause of death?
IVISION or Attending tter death. irrector: After	unetal di	0	examiner?	28a. Date of Injury (Month, Pay Year) 2 2005 28e. Place of Injury - Albuilding, etc. (Spe	4:13/	28c. Injury Work 1 🗆 Y	er: 4 🗆 Nursing H	SUL)	dence 6 Oth	
Hospita 4 hours Funaral	elli (ille	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, death	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the	cause(s) and ma	anner as stated.
To the I within 2 To the I complete	dues	Σ	29b. Signature and title of certifier Car OLI +	Allan	nd	29c. License OCME	e number			d (Month, Day, Year) RY 21, 2005
Rec	Stat	е	30. Name and address of person who con CACL HAC 31. Date filled (Month, Day, Year) FEB 2 8 2005	LADWd 37 Registrar's Sig	noature		Penn Stre	eet Bal	timore,	Maryland 21201

			For State Registrar	State of M	arylan		artment of rtificate of				Reg. No.		0	6583
	Physici	an	1. Decedent's Name (First, Middle, I	and the same of th						2. Date of Dea	Day		ar	3. Time of Death
	/Medic	al	LLSIE 4a. Facility Name (If not institution, g	DIGLER			4b. City, Town,	or Location	of Death	153	19	County of D		1552 LM
	Examin	er	1	SPITAL			BAC	77/2 G	_					
	Funeral		V 10.00	Sex 7. Ac	ge (In yrs.	last birthday)	If Under 1 Yea		24 Hrs. Min.	8. Date of Birt	h Vear	altimo		ce (State or Foreign
	Director		236-40-8372	1□M 2\ F	76	Yrs.	Months Days	Hours	MIII.	8. Date of Birt (Month, Da 03/09/	1928	Ma	arti	nsburg, WV
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						100	d. Inside City Limits
	Maryl f sho	ō	WV Jeffers	on	She	nandoa	h Juncti	on						1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What	Countr	y?
	th wit	a D	PO Box 205				25443	3			US			
	tems	une	11. Marital Status	12. Was Decedent Armed Forces? 1 Yes 2 X	Ever in U.	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)		14. Race - A Black, W		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:	No		1 □ Yes 2🖔 No	Specify:				Specify:	Whit	-e
9	2 hou	Completed by Funeral	15. Decedent's	Education		16a. Deced	dent's Usual Occi	pation			16b. Ki	nd of Busine		
215	thin 7 8. 8n "n	nple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work done DO NOT use retir	ed)	t of workir	ng .				
2	led wi ygien her th	Con	11th			Hc	memaker	T		751		me		
anc	d be fi	Be C	17. Father's Name (First, Middle, La Robert Luther Wh	•						(First, Middle, Branson			hita	
Maryland 21215-0036	should nd Me mark matic	Ը	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree							
	nd 2 salth ar		Debera Kay Spate				Charles							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertil or must be incitited at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3		20b. P	lace of Dispo	sition (Name of natury or other of VI.eW Mel	ace)	D	ate	20c. Lo	cation - City	or Tow	n, State
<u>E</u>	Page ment ant: if ury or		'4 □ Donation 5 □ Other (Spe		FIE	asant Gard		liory	02/23	3/2005	Mart	inshu	ra.	KA
Salt	permit. Depart Import any inj once.		21. Signature of Funeral Service Ltd	eg see		22	Name and Additional Name and Name and	ess of Facilit	tv				200	
	4 C S & G		23a. Part1. Enter the disease, or co	Mores that cause	d the deat			~				2541	4	Approximate
ı	erain.		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	ine.	n. Bo not on				rospiratory ar	1031,		11	nterval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as	a consequ	uence of):	CARCIA	10 M	1	_			1	JEANS
П	Examiner		O and a state of the state of t	b										
-	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):								
ø	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2 000000	uence of):	<u>-</u>							
8760, 🗢	icate be executed physician and s the burial-transit	dical E		255 15 (6) 45	a conseq	uence ory.								
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic		d										
ŏ	leath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnan	°v.			2	23d. Date of		
0.0	ne deat the att hed for	sicis	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4☐ Pregnant a			Other (specify)					Month	D	ay Year
<u>Р</u>	that the de ed by the detached	Phy	9 ☐ Unknown Part fl. Other significant conditions	contributing to death l	out not ree	ulting in the u	nderking cauco g	won in Bart I		23a Did to	abacco u	sa contribute	e to the	cause of death?
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Re	The lav	ошо									rmed?	prior	to comp	Dietion of cause of
ta	an: T	BeC	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only of	ne)	1 🗆 Y	es 🗨	No
	hysici nis ce I direc	To E	examiner? 1 ☐ Yes 2 🗽 No	Hospital: Inpati	ent 2	ER/Outpatien	t 3 DOA	ther: 4 🗆 Nu	rsing Hon	ne 5□Resid	lence 6	3 □Other (S	pecify)	
0 0	ding Physician: The h. h. After this certificate ha funeral director, page		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury	28b. Time of Injury	W	ork?		8d. Describe h	ow infun	y occurred		
sio	death. death. ctor: A y the fu	cat	2 Accident investigat	be 200 Blood of In	ium. At bo	mo form etc		Yes 2		8f. Location (S	troot an	d Alumbor or	- Dural S	Pouto Alumbor
Division of	i or Attendate after death	Certification;	4 ☐ Homicide determine	building, e	tc. (Specify	y)	eet, factory, office	,		City or Tow			nuiair	noute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	edical C	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of examina	wledge, death	n occurred at the vestigation, in my	time, date an	id place, a	nd due to the o	cause(s)	and manner	as stat	ed. ne cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner st	tated.		29c. Licer	se number			29d. Dat	e signed (Mo	onth. Da	av. Year)
	F 3 F 8		1 1 1 1	- who w	V)				34					2005
	1		30. Name and address if rerson wh	o completed cause of	death (Item		Print)	D1 A-	·	BACTI	,		"	7 15 15
	Sta	te	31. Date filed (Month, Day, Year)	A. Registi	301 rar's Signa	ST ture	PAUL	FUTC		VACTO	INC	719		11202
	Registr	ar	FEB 2 8 201	15 Been	, K.	Spa	les .							

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State of Maryland / Department of Health and Mental Hygiene () () 5

06584 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 8,2005 Year FEB. 6:23 P M HERMANTYLER/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGE PRINCE GEORGE'S HOSPITAL CHEVERLY MARYLAND | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | AUG 6 6 1939 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Yrs. 229-48-7141 65 Director VIRGÍNIA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28a-f show rthen "natural", or items 23a or 28a-f shov the Medical Exeminer must be notified at 1 AYes 2 No Maryland P.G. LANDOVER HILLS Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 7106 VARNUM STREET U.S.A.12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: f Yes, Give Year or Dates: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER FRIEGHT17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h CHARLES L. TYLER RUTH NEWMAN TYLER HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Maii Goddress (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if itam 27 is any injury or other trau QDCS. 1706 VARNUM STREET LANDOVER HILLS MD. 20784 RUTH T.SHIRLEY (DAUGHTER) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ZION BAPT. CHURCH 2/12/05 * 4 ☐ Donation 5 ☐ Other (Specify) KINSALE VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY O. WADDY P.O.BOX 305 LANCASTER VA. 22503 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death CARDIAC ARRITYTHMIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical CARDID MYD PATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physicien and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 📈 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? 1 Yes of Vital 2 X No ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification; To funeral dir 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After To the Hospitai or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funarai Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 2 8/95 29b. Signature and title of certific 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD DRIVE GOORAY 3001 HOSPITAL DAVID 31. Date filed (Month, Day, Year) FFR 1 5 20 2. Registrar's Signature State 2005 Registrar

		•	1 - For State of Maryland /		artment tificate			ınd M	_	iene	5	06585
	Physicia		Decedent's Name (First, Middle, Last)						2. Date of Deat Month	Day	Y <i>e</i> ar	3. Time of Death
	/Medic	al	Martha Jane Tarutis						Februa		2005	
	Examin	er	4a. Facility Name (If not institution, give street and number)				Location o	f Death		4c. Count	y of Death arrol	
			Long View Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last by	oirthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth			place (State or Foreign ntry)
	Funeral Director		212-38-0167 1 ¹ M 2 F 81	Yrs.	Months	Days	Hours	Min.	Apr 23,	1923	Newf	oundland
	P .		Usual Residence of Decedent									
	be filed within 72 hours after death with the Maryland Hygiene. Id other than "natural", or items 23a or 28e-f show do other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	ctor	10a. State 10b. County 10c. City, To	wn or Lo	cation		Hamps	stead	Ē			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	I Director	10e. Street and Number 906 Clearview Avenue		10f. Zip	Code	2107	74	10	0g. Citizen of U	What Cou	ntry?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced	ent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		ce - Amen	can Indian,
36	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Y <i>e</i> s 2		Specify:	,	Thousi, oto.,	Specia	_	nite
21215-0036	hours tural,	ed by	3⊠ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16.	a Dece	dent's Usua	I Occup	ation			16b. Kind of B		
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pu	should be filed of Mental Hygie marked other imatic event, III	Be C	17. Father's Name (First, Middle, Last)						First, Middle, N		me)	
yla	should be and Mental is marked o	은	Gilbert White			(0)			beth Hic		01-1- 7	0-4-1
2	nd 2 :		19a. Informant's Name/Relationship (Type, Print) Sandra L. Martin, daughter						ni Route Number, mpstead,			o Code)
nore	00		1 12 Burial 2 Ucremation 3 URemoval from State 11 - 1	ery, crer	natory`or o	ther plac			2/2005	20c. Location Manch		
Baltimore,	permit. Pag Depertment Importent: I any injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00723	22	. Name an	d Addres	ss of Facility	y	Eline Fu	neral	Home	
	205 2 2		Steven willing						Hampste		210	
	= Wat 1		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final		-		0	0	0	9St,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as 1 pms 10 no	(e < v	~ (30	82	Lus	100	-	-	Years
	Examiner			0 017.								ı
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):								
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8760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence	e or):								
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۵.	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying c	ause grv	en in Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?
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900	e law requ has been ge 2 shoulk	Completed							24a. Was ar	n 24b.	Were auto	opsy findings available ompletion of cause of
-		Com							perform	ned?	death? 1 ☐ Yes	2□ M6
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of	Physician: this certific ral director,	2	1 105 212 NO 1 Inpatient 2 EHVC	Outpatier . Time o					me 5 ☐ Reside 28d. Describe ho			fy)
	ding After fune	tlon	27. Manny of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	М	8c. Injun Worl	k? Yes 2⊡!		200. 200020 110	injury occur		
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Ω	pitel cours af		29a. Certifier 1 Certifying Physician: To the best of my knowled	ne deat	h occurred	at the tin	ne date an	d place.	and due to the ca	ause(s) and m	anner as s	stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.			in my o	pinion, dea		ed at the time, da	ate and place,	and due t	o the cause(s)
		2	29b. Signature and title of chainer		200	Sicens	a unuper	05	_ 25	9d. Date signe	ed (Month,	Day, Year)
	WIL		30. Name and address of person who completed cause of death (Item 23a)		Print)		1 and	not.	in Sas	7 31	1074	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		•		1	A.,			1	
	Regist		FEB 1 4 2005 George &	K	park							

			For Stata	State of M	Maryland	/ Depa	rtment of F tificate of	lealth and N		from	005	06586
			Ragistrar 1. Decedent's Name (First, Middle, La	ist)			inouto or	Douin	2. Date of De			3. Time of Death
	Physici /Medio		GEORGE EDW	ARD UHL					FEDYU	Day	18, 200	5 2:55 PM
	Examin		4a. Facility Name (If not institution, giv	e street and number	er)		4b. City, Town, o	r Location of Death			County of Dea	th
			LIONS MANOR NUR					ERLAND			ALLEG	
•	Funeral		5. Social Security Number 6. S	Sex 7 XXM 2□F	Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th i <i>y, Year)</i>	9. Bir	thplace (State or Foreign ountry)
	Director		217 30 1776 Usual Residence of Decedent		72				JUNE 1	1 193	Z MA	RYLAND
	Maryland -f show		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Be-fs	Director	MARYLAND ALLEGAN	Υ	FR	OSTBUE	l.G					X☐Yes 2☐No
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للا	s 23g	erai	100 HONEYSUCKL	E LANE 12. Was Decede	nt Ever in II S	13 V	21532		acity Vac or No	U.S	4. Race - Ame	nocan Indian
2 10	after dea or Itams	Funerai	Never Married 2☐ Married	Armed Force	s?	if	Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, Whit	
-003	2 hours after death with the Marylan atural; or Itams 23a or 28e-f show sal Exer'iberrussi be rollited at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date:	5:	1	☐ Yes 2 🙀 No	Specify:		5	Specify:	WHITE
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≥ 5	within sne.	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. E	O NOT use retired OWNER	d)		CON	amaiiam	TOM
9	Hyg Hyg Hher Int. 1		17. Father's Name (First, Middle, Last,)			OWNER	18. Mother's Nam	ie (First, Middle,		STRUCT	IUN
lan	Ind be fental rked c	To Be	GEORGE REAFORD	UHL				SARAH	SKIDMO	RE		
Maryl	es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie i item 27 Is marked other i r other traumatic event, II		19a. Informant's Name/Relationship (and Number or Rui				
	and 2 ealth m 27		ROBERT GRABENSTE	IN, JR /	FRIEND			STREET,	FROSTBU			
Baltimore			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from Sta	te cen	netery, crem	ition (Name of atory or other plac		785	20c. Loc	ation - City or	Town, State
蓒	it. Pa irtmer irtant: njury		 4 □ Donation 5 □ Other (Specification) 21. Signature, of Funeral Service Licer 		REST		IEMORIAL Name and Addre				LE, MD	O.M.
Ba	permit. Page Department of Important: if any injury or once.		21. Signature of direct Service fices	m	DINGAN	/		ERAL HOME	. P.A.		. MAIN	MD 21532
			23a. Part1. Enter the disease, or com	plications that caus	ed the death.				·		120110,	Approximate
	Physician	8 17	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	7490.	stive	- Paga	+ 1	:000	,	1	Interval Between Onset and Death
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68	tificat ng phy as th		I S S S S S S S S S S S S S S S S S S S									
Вох	death certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne of pregnand 2 Fetal d	;y eath 3 □:	Ectopic pregnancy	,		23	d. Date of del	,
E	ne dea the at hed fo	/sici	1 Yes 2 No	4□Pregnant 9□ Unknown	at time of dea	th 5□	Other (specify)				Month	Day Year
P.O.	that the ed by detac		Part II. Other significant conditions of	ontributing to death	but not resulti	ing in the un	dertving cause give	en in Part I.	23e. Did to	obacco use	e contribute to	the cause of death?
ds,	uires sign	d by	Diabetes	mellit		Hybe	rtensio	n.	101	/es 2□	No 3□Pr	obably 4 Unknown
2	s beer	Completed	Parkinson	is Di	Sease	2 . v	n nachai	ما	24a. Was	an	24b. Were au	topsy findings available completion of cause of
Be	The la	E O	Obesity							rmed? 2 🐧 No	prior to death? 1 ☐ Yes	completion of cause of
ita	stan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					26. Place of Deat		/\		73.10
of V	hysic this ce	ို	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		R/Outpatient	3□ DOA Oth	4 X Nursing Ho	me 5 Resid			cify)
n C	Jing F	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 2 Day Year)	8b. Time of Injury	28c. Injun Worl	yat k? Yes 2 ⊡No	28d. Describe h	now injury	occurred	
Division of Vital Records,	Attence death ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 29a Diesa of I	niury - At hom	e. farm. stre	et, factory, office	192 5 140	28f. Location (S	Street and	Number or Ru	ıral Route Number.
Div	al or / s after Il Dire	Certi	4 ☐ Homicide determined		etc. (Specify)	-,,	ou motory, omoo		City or Tou			
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. within 24 hours after death. to the Funcural Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 12 Certifying Ph	ysician: To the bes	of my knowle	edge, death	occurred at the tin	ne, date and place,	and due to the	cause(s) a	nd manner as	stated.
•	the H hin 24 the F nplete	Medicai	one)	and manner	stated.	i and of Inve						
	To To	4	29b. Signature and title of certifier		11 .	. 0	29c. License	e number	11.	29d. Date :	signed (Month	DAY, Year)
	0	-	20 Name and address of access the	Jan	doub (line ?	MW	17 D	1446	7	KDY	uary	18,0003
	1		30. Name and address of person who	Completed cause of	ueain (item 2	Oa) (Type, P	11111)	1000	5-1	10211-		01/0-
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	tur's Signatur	0 10	rn le	rrace	Trost	Dur.	g, M	> 21532

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item #26 State of Maryland / Department of Health and Mental Hygiene [] 5
Reg. No.

Reg. No. 06587 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician 2:30 A.^N February 14,2005 Mary Virginia Vaughn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport
If Under 1 Year If Under 24 Hrs. 9629 Cafoxa Dr. <u>Washington</u> Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 212-24-2880 1□M 2√F 75 Yrs. Director Oct. 18, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar coust be notified at 1 XYes 2 No Director Washington MDHagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death v 1429 Hamilton Blvd. 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛐 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ۵ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Glenn Kline Cline Alice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9629 Cafoxa Dr. Williamsport, Shurl L. Bussard MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2/16/2005 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St. Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner CONORAR ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was en performed? Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home — Statement 6 Dother (Specify) home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02/14/05 052323 (2a

JH-16

State Registrar Dr. K. Waseem, MD, 1126 Opal Court, Hagerstown, MD 21740

1. Date liled (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date liled (Month, Day, Year)
FEB 1.6 2005
32. Registrar's Signature

			1- For Amend Item 26 State of Maryland, Department of Per Verb, 6840, 62728/056 Certificate of C	Health and I hb of Death	Mental Hygie	enje () ()	5	06588
	Dharaisi		Decedent's Name (First, Middle, Last)		2. Date of Death			3. Time of Death
	Physici /Medic		Mary Elizabeth WILLIAMS		FMBRUAR			8:40 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 13915 MAUGANSVILLE AVE RD 4b. City, Tow MAUGA	m, or Location of Death NSVILLE	1	4c. County o WASHI	NGT	ON CO
	Funeral Director		245-47-5907 34 Yrs.	ear If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 7 1	(ear)	9. Birth Cou Flor	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	Maryl -f sho lied a	tor	Maryland Washington Maugansville					1 ☐ Yes 2 📉 No
	r 28a	Director	10e. Street and Number 10f. Zip Coc	de	100	g. Citizen of Wi	hat Cou	ntry?
	23a c	alD	13915 Maugansville Road 2	21767		U.S.A.		
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2	hould d Mer marke	은	Thomas George Malek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str		h Anne Br		State Zir	Code
	nd 2 s lith an 27 is r treu		Thomas G. Malek - Father P.O. Box 123				nato, 21).	7 0000)
Baltimore,	of Head		20a. Method of Disposition 20b. Place of Disposition (Name of			c. Location - C	ity or To	own, State
Ĕ	Page ment a ant: If ury or		1 Burial 2 XCremation 3 Removal from State 1 Donation 5 Other (Specify) Hagerstown Crem.		/05	Hagers	tow	n, Maryland
3att	Depart Import Import any inj		21. Signature of Funeral Service Licensels 22. Name and Ad	ddress of Facility	Minnich F			
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ı	Examiner							
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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	To the H within 24 To the F complete	Medical	one) and manner stated.					
1	wit To	-	29b. Signature and title of cartifile 29c. Lice	ocme		. Date signed (BRUARY		
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
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Funeral Director		5. Social Security Number 218–90–9943		ge (In yrs. las 44	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y 12/24/60	ear) 9. Bi	rthplace (State or Foreign country) EVERLY, Md.
and	1	Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Lo	cation				10d. Inside City Limits
Mary f she	ō	Md.	P.G.			Lani	ham			1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified alonge.	Funeral Director	10e. Street and Number		1		10f. Zip Code		10g	. Citizen of What C	country?
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permi Depa Impo any i		21. Signature of Funeral Service	/) (I	. Name and Address Name and Address Name and Address Nashi	ington &	Sons Co.,	nc.	
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o the	Me	29b. Signature and title of certifie				29c. Licens	se number	29d.	Date signed (Mon	th, Day, Year)
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	/Medio		BERNARD 4a. Facility Name (If not institute)	WHITE, JR.			4b. City, Town,	or Location		FEDRUF		County of E		4:33 P
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			DOCTOR S C 5. Social Security Number	OMMUNITY F	OSPITAL 7. Age (In yrs. Ia	at hinth days)	L. If Under 1 Year	ANHAM		8. Date of B				ORGE'S
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	pu ≱		10a. State 10b. Cour	ty	10c. City.	Town or Loc	ation						100	I. Inside City Limits
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an	2 should be f and Mental I Is marked of aumatic eve		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing	Address (Street	and Numb	ber or Rurai	i Route Numi	ber, City or	Town, Stat	te, Zip C	ode)
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5	f Hear item othe		20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name of atory or other pla	ce)	Da	ate	20c. Loc	cation - City	or Town	n, State
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	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral		29a. Certifier 1 Certification (Check only 2 Medic	ying Physician: To th	e best of my know	ledge, death	occurred at the ti	me, date a	nd place, a	nd due to the	cause(s) a	and manner	as state	ed.
	n 24 n 24 ne Fu	Medical	one) 2 Medic	al Examiner: On the and mai	pasis of examination nner stated.	on and/or inve	estigation, in my o	opinion, ae	ath occurre	d at the time,	, date and p	place, and o	due to th	e cause(s)
	To the To the Comp	ž	29b. Signature and title of certi	fier /		1	29c. Licens	se number			29d. Date	signed (Mo	onth, Da	y, Year)
	-		> /luss	1 / //	11111	1	1)(OI	20	72	Feb	ruary	7.	2005
	(1)		30. Name and address person	nn who completed car	use of death (Item 3	23a) (Type P	Print)					- 7	, ,	
1			Myron I. Mu			-	er Pkwy	S111 +	e 206	Gree	nhe1t	., Md.	20	0770
	Sta	to.	31. Date filed (Month, Day, Yes	(ar)	Registrar's Signatu		104V y					, ,,,,,,		
	Registr		31. Date filed (Month, Day, Yo.	2005	en &									
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, State Amended #10d perFH ; FCHD TM 62/4/16/2005 Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2005 FEB. 11, 11:05 A M DONALD WOLDEN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mount Carroll Airy 809 Merry Go Round_ Way 8. Date of Birth (Month, Day, Year) AUG. 2, 1926 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1₽M 2□F Yrs. Wisconsin 722-16-9852 78 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-1 show the Medical Examiner must be notified at Maryland Carroll Mount Airy 1X Yes WN Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or 809 Merry Go Round Way 21771 United States death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 127 Yes 2 No
If Yes, Give
Year or Dates: 1944-45 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. ģ 3 Widowed 4 Divorced White natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Photo Analyst Government other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked o Wolden Scheluan Anton Car1 Helga 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlotte R. Martin Wolden/wife 809 Merry Go Round Way / Mount Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 16 Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once. MD. Veteran, Rocky Gap | 02/16/2005 | Flinstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 8 E. Ridgeville Blvd./ Mt. Airy, MD 21771 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Extensive Metastatic Prostrate Cancer 5 yrs. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day signed by the atte in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ASCVD, High BP, Cholesterol 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1□ Yes 2∏ No Division of Vital To Be 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 V Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier Cole iny D14626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $P. \quad Gregory \quad , \quad 501 \quad W. \quad 7th \quad St. / \quad Frederic$ 7th St./ Frederick, MD 21701 32. Régistrar's Signature 31. Date filed (Month Day Year) 4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115

			State Registrar	State of Maryl	and / Depa	artment of H	lealth and Me Death	Reg		6592			
	Physici	an	Decedent's Name (First, Middle, Last)		1			Date of Death Month	10, 2005	3. Time of Death			
	/Medic	al			Walters			ebruary		11:25 A ^M			
	Examin	er	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Death	1_			
			14526 Bollinger Ro		yrs. last birthday)	Rocky I	-	Date of Birth	Frederic				
L	Funeral Director			M 2 ₹ 87		Months Days	Hours Min. 0	Date of Birth (Month, Day, Y)	917 Indi	place (State or Foreign ntry) ana			
	and and		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits			
	Maryl	ŏ	Maryland Frederic	·k	Freder	ick				1 ☐ Yes 2x No			
	28a	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?			
	3a or	<u></u>	1820 Latham Drive			2170)1		USA				
	ma 2	era	11. Marital Status	2. Was Decedent Ever	in U.S. 13.	Was Decedent of H	ispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	14. Race - Americ				
36	urs after o al', or Iter	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2x⊡x No	sn, мехісап, Риело ніс Specify:	an, etc.)	Black, White, Specify: Wh				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any riqury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working	16	b. Kind of Business/In	ndustry			
21.	giene giene	No.	12	, , , , , , , , , , , , , , , , , , , ,		Recepti			Hospital				
פ	othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (F	First, Middle, Ma	iden Sumame)				
<u>a</u>	Menta Menta rked	10 E	0 r pheus	Kerr			Haze1		(Unknown)				
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationship (Typ. Linda Denniston/Da				and Number or Rural F ger Road, R						
Baltimore,	r Hear Hear Hear Hear Other		20a. Method of Disposition	2	Ob. Place of Dispo	osition (Name of matory or other place	Dat	e 20	c. Location - City or To	own, State			
9	age anto it: ff		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			m. 2/23/2	005 A	rlington,	VA			
	artme artme ortan injur		21. Signature of Funeral Service License				ss of Facility Stau						
Ba	Depariment of the population o		1 Locale MOR	2			n Street,			-			
	/Medical Examiner	Examiner	23a. Part 1. Extentine disease, or complishook on bear failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2.12.40	nsequence of):				arrest, Approximate Interval Betwood Onset and D				
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a co	regnancy Fetal death 3 [□Ectopic pregnance	/		23d. Date of deliving Month	ery Day Year			
<u>α</u>	that the		Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to I	the cause of death?			
Records,	signe d be	d by		isease				1 🗌 Yes	2 No 3 □ Pro	bably 4 □Unknown			
0	w require	Completed						24a. Was an	24h Were aut	opsy findings available			
Sec	e law has l	Idu	CHF					autopsy	prior to co	ompletion of cause of			
<u></u>		S	Osteoporosis.					1	No 1 Yes	2 No			
Vita	ician: Th certificate rector, pag	Be	25. Was case re erred to medical examiner?	fospital:		Ott	26. Place of Death (Daughter'			
o	Phyaician: this certific ral director,	2	1 Tes 20 No	1 Inpatient	2 ER/Outpatie		ner: 4 ☐ Nursing Home	 5 Residen d. Describe how 		Hofie			
Ë	ding F n. After funer	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye		Wo		d. Describe nov	injury document				
Division	l or Attend after death Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)			f. Location (Stre City or Town,	et and Number or Rur State)	ral Route Number,			
۵	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical Ce	29a. Certifier 175 Certifying Physical (Check only one) 2 Medicel Exami	sicien: To the best of m ner: On the basis of exa and manner stated.	y knowledge, dea amination and/or in	th occurred at the ti nvestigation, in my o	me, date and place, an opinion, death occurred	d due to the cau I at the time, dat	ise(s) and manner as a e and place, and due t	stated. to the cause(s)			
	ro th vithin ro th compl	₹	29b. Signature and title of certifier	•		29c. Licens		290	d. Date signed (Month,	Day, Year)			
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	St	ate	31. Date filed (Month: Par Year) 4	1115 32. Constrar's	Signatur	MARAGE							

Registrar

		-	1 - For State of Maryland / Registrar		artment of H rtificate of L		Mental	Hygier		06593
			1. Decedent's Name (First, Middle, Last)				2. Date Mon	of Death	Day Yee	3. Time of Death
	Physicia /Medic		GERTRUDE ELIZABETH WILLIAMS					ruary	2 200	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		th		4c. County of De	eath
			Sunrise Assisted Living		Silver				Montgo	
п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date (Mor	of Birth oth, Day, Yes 25,	9. 6	Birthplace (State or Foreign Country)
	Director	-	401.36.0300 12 Miles 82	110.			Aug	. 25,	1922 Ch	icago, ILL
000	A TI		10a. State 10b. County 10c. City, To	wn or Lo	cation					10d. Inside City Limits
M	in the state of th	to	Maryland Montgomery Kens	sing	ton					1⊠Yes 2□No
\$ 5	r 28a	Directo	10e. Street and Number		10f. Zip Code			10g.	Citizen of What	Country?
4	23a o	aiD	9842 LaDuke Drive		20895			U	.S.A.	
9	S We	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	Specify Yes	or No-	14. Race - Ar Black, W.	nerican Indian,
က္က	or its	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		1 ☐ Yes 2 ☒ No	Specify:		,	Specify: 1	
d 21215-0036	LENG!	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:					1	I A	merican
<u>.</u>	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wo	rking	16b	Kind of Busines	ss/Industry
12	than	mc	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Years		cher	,		_ 1	Educatio	n
2 2	Hygi Hygi other ant, 1	ပိ	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, I			
al	ental ked c	To B	Oral Strode McClellan			Mamie	Burns	West		
Maryland 21215-0036	S should be men within 12 hours are been must be waysan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modical Exeminer mast be notified at	-	19a. Informant's Name/Relationship (Type, Print) Daughter	9b. Maili	ng Address (Street a	and Number or R	ural Route	Number, Cit	y or Town, State	a, Zip Code)
ž į	alth a				Blanton					
e .	item other		20a. Method of Disposition 20b. Place cemei	of Dispo	sition (Name of matory or other place	θ)	Date	20c.	Location - City	or Town, State
E E	Ary in a grant			gtor	Nat'1 Ce	eme. 02/	09/20	05 Ar	ington,	Virginia
Baltimore,	perimit. Tages a raid a should be propertiment of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licensee	H 1	NES-RINAL	s of Facility	рат н	OME 1	NC	
m ;	70 E 29		Nancy A Parcon he	171	<u>1 wew 1008.</u>	dampshir	e Ave	, Silv	er Spri	ng, MD 20904
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not en	er the mode of dying	g, such as cardia	c or respira	itory arrest,		Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition a		Alzheimer	rs Disea	se			Oriset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence)	e of):			300.45			
		_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e off.						
7	nsit led	nine	cause. Enter Underlying Cause (Disease or injury	0 01).						
	al-trai	Examiner	that initiated events c. Due to (or as a consequence	e of):						1
Records, P.O. Box 68760,	ate be executed hysician and the burial-transit		C _d							
89	g phy as th	Physician/Medical								
Вох	attending phase as the	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	th 3.	Ectopic pregnancy				23d. Date of c	*
	inal the dealt cer ed by the attendin detached for use	sicis	1 Yes 2 No 4 Pregnant at time of death		Other (specify)				Month	Day Year
P.O.	d by the	Phy	9 🗆 Unknown			-	00-	Didastr		to the course of death 0
ທົ່	signed	by	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause give	en in Parti.	238	. Did tobacc		to the cause of death? Probably 4 □Unknown
orc	been si	eted						-		
Records,	has b	Completed		-			24a	 Was an autopsy performed 	prior t	autopsy findings available o completion of cause of
<u> </u>							10	Yes 2	Vo 1 ☐ Y	
<u> </u>	certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Othe	26. Place of De				
ō	2 = 6	. To	1 ☐ Yes 2 ☑ No	. Time o	IL 3L DOA	4 Nursing r			6 Ki Other (S)	Decify) Assisted Living
uo ,	th. : After funer	tior	1 X Natural 5 ☐ Pending (Month, Øay Year) 2 ☐ Accident investigation	Injury	Work	k? Yes 2 □No				LIVING
Division of Vital	or Attending Proystotans: after death. Director: After this certifical in by the funeral director.	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm, str	eet, factory, office					Rural Route Number,
á	2 4 5 5	Cert	4 ☐ Homicide determined building, etc. (Specify)				City	or Town, St	110)	
	io the hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only (C							
	thin 2 the I	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. I	Date signed (Mo	nth. Dav. Year)
	- 3 - 8		1/2/4 }			MD117	93			8, 2005
	15		30 Name address of person who completed cause of death (Item 23a	ı) (Type,	Print)					J, 2005
_			Jay Wilder, MD, Walter Reed	Arı	ny Medica	L Center	, Was	hingto	on, DC 2	0302
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Lon	uli	-		0 -		
	- F. Y. 1133 F.	ar	FEB 1 0 2005 Reference St.	No. of Street, or other Persons						

State of Maryland / Department of Health and Mental Hygien 0 0 5 06594 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** February 9, 2005 0530 Eileen Harris Wratchford /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Yrs. 465-54-1678 Usual Residence of Decedent Director Nov 15, 1936 New Hampshire 68 with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Examinar must be nutified at 1√2 Yes 2 □ No Director Maryland Carroll Manchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21102 USA death v Funerai 2903 Tulip Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of Maryland College (1-4or 5+) Elementary/Secondary (0-12) Juvenile Justice Restitution Clerk 12 n 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Chester Selwyn Harris Frieda Schmerder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manchester, MD 21102 20c. Location - City or Town, State 2903 Tulip Way P.O. Box 767 William Wratchford Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Woodlawn Cemetery 2/12/2005 Woodlawn, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licenses 412 Washington Rd. Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** psis disease or condition resulting in death) /Medical Due to (or as a consequence of): Due to (or as a consequence on: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit requires that the death certificate be executed Le Myelong 1eta State resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 UN To the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 2 N 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending within 24 hours after death

To the Funeral Director: A
completely filled in both death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier i 🗓 👀 Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title 1244 02-05-2005 +0054218 WIL 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 B. Kanery Kaman Malcilm dun 349 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

			State of Maryland / Dep 1- State Amend Item 5 per fh G841 3-2-200 Registrar	artment of Health and Me Dirtas Prificate of Death	ental Hygiene 0 0 5 0 6 5	95
	0.		Decedent's Name (First, Middle, Last)	2	2. Date of Death 3. Time	of Death
	Physicia /Medic		James R. Wilson	F	ebruary 13,2005 3:0	00a ^м
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
			31 Ridge Run	North East	Cecil	
	Funeral Director		5360-16-9674 6. Sex 1	Months Days Hours Min.	Date of Birth (Month, Day, Year) Sarch 8,1927 IL	or Foreign
	D *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside	City Limits
	darytan f show	0		h East	1	s 2 No
	the 128a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	3a or		31 Ridge Run Rd.	21901	U.S.A.	
	deatl	Funeral		. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wedical Examilian out be notified at	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1945	1 ☐ Yes 2 🛣 No Specify:	Specify: White	
0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry	
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
	ed will ygien yellen ser th	Cor		cutive Manager	Auto Dealer First, Middle, Maiden Surmarne)	
Maryland	12 should be filed within and Mental Hygiene. Tis marked other than "raumatic event, the Mes	Be	17. Father's Name (First, Middle, Last) James Wilson		Williams	
IZ I	should od Me mark matic	은			Route Number, City or Town, State, Zip Code)	
Ma	alth ar 27 Is 37 Is			Ridge Run Rd., N	North East, MD 2190	01
ē,	of Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition	position (Name of Day	te 20c. Location - City or Town, State	
Ë	Page le∩to nt:If		1 M Burial 2 I Cremation 3 Hemoval from State	khon's Cemetery	18,2005 South Cana	aan, Pl
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Litensee	22. Name and Address of Facility	neral Home	
			23a. Part 1. Enter the disease, or omplications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	259 East Main St nter the mode of dying, such as cardiac or	respiratory arrest, MD 210	2 1 ate
			Immediate Cause (Final	an Ce	Interval B Onset and	d Death
	/Medical		disease or condition resulting in death) a Due to (or as a con/equence of):	ma		
	Examiner		Sequentially list conditions			
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. For at Indentyin, Cause (Disease or injury			
	e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
8760,	be ex ician burial	a E	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5			
687	icate physics the b	edical	d			
Box (leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
	death e atte d for	Physician/M	in the past 12 months? 1 Ves 2 100 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day	Year
0	that the de ed by the detached	hys	9 Unknown			
Records, P.	es gn be	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of	
cor	w requir been si should	Completed			24a. Was an 24b. Were autopsy finding	s available
Re	i cian : The lav certificate has rector, page 2	шо			autopsy performed? performed? performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	cause of
Vital	an: T	0	25. Was case referred to medical	26. Place of Death (
Į V	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Home	e 5 Mesidence 6 Other (Specify)	
n of			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 28a. Date of Injury (Month, Day Year) Injury		d. Describe how injury occurred	
Sio	Attending r death. ector: After you the fune	catle	2 Accident investigation	M 1 Yes 2 No		
Division	al or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28	M. Location (Street and Number or Rural Route Nu City or Town, State)	mber,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or and manner stated.)(s)
	To the within To the Complete complete	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
			Kolom Dummer MS	D8056449	2/14/05	
ĺ	0+1VA		30. Name and address of person who completed cause of death (Item 2βa) (Type	a, Print) SI SI SI	D2 FIKTO MD :	21921
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	90101. alle c	م در المالان	-10
• •	Regist		FEB 1 6 2005 Bleen & Species	/		

			For State Registrar	State of I	Maryland /	Depa Ce	artment rtificate	of H	ealth a Death	and M		giene Reg. No.	005	06596
	Dhysiai		1. Decedent's Name (First, Middle, Las	t)							2. Date of De.	ath Day	Year	3. Time of Death
	Physici /Medic		Betty Jane Western								Februa	ry 1	2,2005	11:00 P M
	Examin	er	4a. Facility Name (If not institution, give	street and number	ər)				Location of	of Death		4c.	County of Deat	h
	Europel		72 Calvary Lane 5. Social Security Number 6. Se	9x 7.	Age (In yrs. last b	irthday)	Risi If Under	1 Year	un If Under	24 Hrs.	8. Date of Birt	h	cil 9. Birt	hplace (State or Foreign
	Funeral Director			□M 2 X)F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da Iarch 2	y, Year)	Co	vland
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	um or La	onting					, , , ,		
	Aaryla I sho	ō												10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the the 28a-	Directo	Maryland Cecil 10e. Street and Number		Rising	3 Su	n 10f. Zip	Code				10a. Citi	zen of What Co	untry?
	h with		72 Calvary Lane				219	1.1					ed Stat	
	ems sermi	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13.			spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	OILLE	14. Race - Ame Black, White	rican Indian,
36	d within 72 hours after death with the Maryland jeene. rrthan "natural", or Items 23s or 28s-f show the Medical Esarth arrmust be Lodiffed at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2∑ If Yes, Give	□ No		1 □ Yes 2		Specify:		, , , , , , , , , , , , , , , , , , , ,		Specify:	
21215-0036	tural tural	ed b	15. Decedent's Ed	Year or Date		a. Dece	dent's Usua	l Occupa	ution			16b Kir	Wh nd of Business/	ite
215	within 72 ene. than "ne he Medir	Completed	(Specify only highest grade	de completed) College (1-4)		(Give	kind of wor DO NOT us	k done o	lurina mosi	t of workir	ng	100.10		moustry
7	filed withi Hygiene. Ither than	Com	8			omem	aker					Own	Home	
III	ed a b	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
Maryland	should be ind Mental marked o	2	Andrew Benjamin Fe		10	h Maili	a Address	(Street o	Mabe 1	l Vir	ginia]	Bryan	n r Town, State, 2	Zio Oo dol
Z			Stephanie Pierce/I		4								nd 2191	
ē,	is 1 and 2 of Health a item 27 ls othar trae		20a. Method of Disposition		20b. Place	of Dispo		ne of			ate		cation - City or	
Ĕ	Page nent c ant: If ary or		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		North	Éas	t Meti etery	hodi		ebru	ary 17	North	th Fact	.Maryland
Baltimore,	permit. Pages i Department of F Important: If ite any injury or ot once.		21. Signature Pungal Service Lee	ee /		22	. Name and	d Addres	s of Facilit	y Cro	uch Fu	nera	1 Home	, rary rand
	20 E E G		post ile										st,Mary	land 21901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that causone cause on each	sed the death. Do	not ent	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a	H D C	_ \								years
8	Examiner				as a consequence	a or):								/
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Others or triury	Due to (or	as a consequence	a of):								
	ecute and -trans	Examine	that initiated events resulting in death) Last	C. Due to for	as a consequence	4\-								
8760,	be executed sician and burial-transit			. Due to (or	as a consequence	a Oi).								
687	ificate p physics the	Physician/Medical		d							-			
ŏ	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnancy	h 3[Ectopic pre	ananau				2	23d. Date of del	ivery
O.B	it the deat by the att tached for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death		Other (spe						Month	Day Year
P.0	that the		9 ☐ Unknown Part II. Dther significant conditions co		-	in the u	nderhing o	THEO CINE	un in Part I		23a Did to	phacco II	se contábute to	the cause of death?
Records,	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	ted by	Paril. Dittor significant contantoris of	onthibuting to deat	T but not resulting		nderlying ca	iuse give	mmrant.			es 2[
ec	e faw i has b	Completed									24a. Was autop	sy	prior to o	topsy findings available completion of cause of
alF	. a c										1 ☐ Yes	rmed? 2DNo	death? 1 ☐ Yes	2000
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	Hospital: 1 ☐ Inp	atient 2 ER/C	Outpation	nt 3 DO	Δ Othe	· -	of Death	(Check only o	-	COther (C	- 'A.\
J of		 	27. Manner of Death	28a. Date of I		. Time o Injury		Bc. Injury Work		-	28d. Describe h		Other (Spector)	suy)
Sior	Attending I r death. sctor: After by the funer	atio	1 Accident 5 Pending investigation		Say roar,	mjury	М		res 2 🗆 1	No				
Division	tal or Attenders after death al Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home, etc. (Specify)	farm, sti	reet, factory	, office		2	28f. Location (5 City or Tox			ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the be niner: On the basi and manner	s of examination a	ge, deat and/or in	h occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the o ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
)	To the Pwithin 2: To the I	Σ	29b. Signature and title of contifier		N	N	29c.	License	number 560	44	9	29d. Date	e signed (Mont	n, Day, Year)
	5		30. Name and address of person who delices the second seco	completed cause	of death (Item 23a	(Type,	Print)	2 6	Th	(La	MN	21	192	/
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 5 2005	32. Reg	istrar's Signature	and the	,			VV			1	

Chri.	stiana 1 1342	Maı	cie Willia	^{mS} Pleas	se Typ	e or P	rint in I	Black II	ndelib	le lnk	. Ens	ure Al	I Copies	Are	Legi	ible.		
RJ						ate ot 1	Marylar Ba-f I	per me	ertifica	nt <u>of</u> d	lealth Death	and M as 7	tental Hy	giene Reg. No.	20	05	0659	7
	Physicia	an	Decedent's Name										2. Date of De Month	Day		Year	3. Time of Death	
	/Medic	al.	Christina 4a. Fecility Name (If				er)		4h Cih	v Town o	or Location	of Deeth	Februa		20,	2005 of Death	09:21 F)M
	Examin	er	Washington		-			ı		ersto		O Deeti					n County	
2	Funeral		5. Social Security Nu		6. Sex	7.	-	last birthday		er 1 Year		or 24 Hrs.	8. Date of Bir (Month, Da	th	40111		lace (State or Fore	ign
10	Director		218-23-51 Usual Residence of I		1 🗆 M	5X1+	20	Yrs.		Days	Hours		Aug. 30		84	Mary.		
4)	land			10b. County			10c. Ci	ty, Town or I	ocation							1	0d. Inside City Lim	its
	Many Pefsh	tor	Maryland	Washi	ngton			Hager	stown	1							1★ Yes 2 🗆 I	No
	or 28	Director	10e. Street and Num	ber						ip Code				10g. Citi	zen of \	What Cour	itry?	
	ath w	rail	50 E. Nor	th Ave						217					.S.			
	items	Funerai	11. Marital Status 1 Never Marrie	d 2□ Marri	A	Vas Decede Imed Force ☐ Yes 2]		J.S. 13	. Was Dec If Yes, sp	edent of F ecify Cub	lispanic O an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.))-		ck, White,		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examitter is used by inflied at once.	by	3 Widowed 4		l f	Yes, Give ear or Date	-		1 🗆 Yes	2 X No	Specify	y:			Specify	y: Wh	ite	
2-0	72 ho	Completed		15. Decedent y only highes				16a. Dec	edent's Us e kind of w	ual Occup	ation	set of work	ina	16b. Kii	nd of B	usiness/Inc		
2	within ene.	mpie	Elementary/Secon	<u> </u>	C	College (1-4	or 5+)	life.	DO NOT	use retire	d)	St Of WORK	ing					
2	filed w Hygier other tl		12 17. Father's Name (F	First Middle I		2		Dat	a Ent	ry	19 Moth	nor's Name	(First, Middle			ocess	ing	
and	d be f	To Be														110)		
ary	should be ind Mental is marked o	F	Harry Pat 19a. Informant's Nar					19b. Mai	ling Addres	ss (Street			e Yvonn			State, Zip	Code)	_
Ž	and 2 ealth a n 27 is		Constance	Willi	ams -	Moth	er	50	E. No	rth .	Avenu	ie. Ha	agersto	wn.	Md.	2174	0	
ore	of He of He fiter		20a. Method of Dispo		3	val from Sta		Place of Disp cemetery, cri	position (Na	ame of			Date			City or To		
Ē	Pag tment tant: jury c		*4 □Donation	5 ☐ Other (Sp	ecity)		Нар	gersto				2/21					Maryland	
Bai	permit. Page Department of Important: if any injury of once.		21. Signature of Fun	eral Service I	icensee	-0	an.						nnich F				017/0	
			23a. Part 1. Enter the	e disease, or	complicatio	ns that cau	sed the deat			_			. Ilage		wn,	Md.	Approximate	
	Dhusisian		shock, or heart Immediate Cause (F	tailure. List i Final	only one ca	use on eac	n line.				19, 000, 0	3 cardiao c	or respiratory a	11001,			Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	1)	a. N	arcot: Due to (or	ic in	itoxica quence of):	ation									
	Examiner		Sequentially list con-	ditions	b													
	D =	iner	if any, leading to imr	nediate lying	, "	Due to (or	as a consec	quence of):								-		
	executed n and ial-transit	Examiner	that initiated events resulting in death) La	njury -	c	Due to (or	as a consec	mence of):										_
,60		_				000 (0 (0)	us a consec	4001100 OI).										
687	death certificate be e attending physicis id for use as the bu	edic			d													
ŏ	h cert ending	In/M	IF FEMALE: 23b. Was decedent				ne of pregna		□ Fatania					. 2	23d. Dai	te of delive	ry	
Э.	s deat he att	sicia	in the past 12 n		4		t at time of c		□Ectopic □ Other (s		/				Mo	onth	Day Year	
Division of Vital Records, P.O. Box 6876	The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	by Physician/Medical	9 Unknown Part II. Other signific	cant conditio							. '. D		00- 014			3		
ds,	signe d be c		raitii. Other signiin	carr conditio	113 COMMIDU	iting to deat	II DULIIOLIGS	sulting in the	underlying	cause giv	ren in Pan	1.				noute to th	e cause of death?	wn
Sor	w requir been si should	iete											24a. Was		T			
Re	he lav e has	Completed											autor perfo	rmed?	1 6	prior to con death?	osy findings availab appletion of cause o	of .
tal	i clan : Th certificate rector, pag	a	25. Was case referre	ed to medical				· · · · · · ·			26 Plac	e of Death	12 Yes	2 No	1	Yes	2□ No	
<u>></u>	Attending Physician: It death. ector: After this certifica by the funeral director, p	To B	examiner? 1 XYes 2 □ N	10	Hospi	tal: 1 🗌 Inp	atient 2X	ER/Outpatie	ent 3 🗆 🗈	Oth			me 5 ☐ Resid		i □Oth	er (Specify)	
0 1	ng Pt After th		27. Manner of Death	5 C Pending		Ba. Date of I		28b. Time 8:45	of	28c. Injur Wor	y at k?		28d. Describe h				_	
sio	or Attending after death. Director: After in by the funer	Certification:	2 Accident 3 Suicide	investig	ation f	ound		toung	$1 \mathbf{p}^{M}$	1 🗆	Yes 2							
Οį	for Al after of Direction by	ertif	4 Homicide	determi	ned 28	building,	etc. <i>(Specil</i> at hom	ome, farm, s	treet, facto	ory, office			281. Location (S City or Tox	Street and vn, State)	50	E. No	Route Number, orth Aven	ue
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page		29a. Certifier	1 Certifyin	g Physicier	n: To the be	st of my kno	owiedge, dea	ith occurre	d at the tir	ne, date a	nd place a	lagersto	cause(s)	and ma	inner as st	nated	
	ne Ho ne Fur ne Fur	edicai	(Check only (210 Medical I	Examiner: (On the basi and manner	s of examina	ation and/or i	nvestigatio	n, in my o	pinion, de	ath occurr	ed at the time,	date and	place,	and due to	the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and t	itle of certifier	\cap	,	1.1		25	9c. Licens	e number			29d. Date	e signed	d (Month, l	Day, Year)	
			>		YN	M	Lt			OCME				Feb	rua	ry 21	, 2005	
			30. Name and addre				of death (Iter	m 23a) (Type		111	D	a.						
	Sta	to	31. Date filed (Month	n, Day, Year)	n. Ti	32.5Red	istrar's Signa	ature	_	111	renn	Stree	et Bal	timo	re,	Mary.	land 2120)1
*	Registr		FE	B 2 8	2005	Live,	a s		arte)	5								

			For State Registrar	State of Maryland	/ Depa <i>Cer</i>	irtment of Hea tificate of De	alth and N e <i>ath</i>		giene	005	06598
			1. Decedent's Name (First, Middle, Last					2. Date of De		Year	3. Time of Death
	Physicia /Medic		Betty Jone	young				Februar		2005	- 4:41 AM
1	Examin	er	4a. Facility Name of not institution, give			4b. City, Town, or Lo			,	ounty of Deat	
	Funeval		Washington County 5. Social Security Number 6. Se	7. Age (In vrs. last	birthday)	Hagerstow If Under 1 Year If	Under 24 Hrs.	8. Date of Bir (Month, Da		shingto 9. Bird	DN hplace (State or Foreign untry)
	Funeral Director		212-24-5842]M 2XF 78	Yrs.	Months Days H	Hours Min.	Dec.	1 <i>y, Year)</i> 24 19:	26 M	ary1and
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits
	Maryl -f aho	tor	Maryland Washing	ton	Надел	stown					1∰Yes 2 No
	th the or 28a e notif	Director	10e. Street and Number	CO11	na ₅ c.	10f. Zip Code			10g. Citizer	n of What Co	untry?
	ath will		12 S. Walnut Stre			2174				S.A.	
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. \	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.))- 14.	. Race - Ame Black, White	
336	within 72 hours after death with the Maryland ilene. rthan "natural", or Items 23a or 28a-f ahow Ite M. Jicel Exa , it et must be notified at	by	3 ☐ Widowed 4 🕅 Divorced	If Yes, Give Year or Dates:		☐ Yes 2X No S	Specify:		Sp	pecify: Wh	ite
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		6a. Deced	lent's Usual Occupation kind of work done during	n na most of work	dina	16b. Kind	of Business/	Industry
121	within ene. than the fire Max	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)			T		
d 2	Hyg Tha	e Co	8 17. Father's Name (First, Middle, Last)	U	ьат	ındry Servi		e (First, Middle		indry Imame)	
lan	should be to marked of mar	To B	Robert Lee Dodson			Le	eola Gel	lwicks			
Maryland	0 6 6		19a. Informant's Name/Relationship (7)	1		g Address (Street and					(ip Code)
	is 1 and 2 should of Health and Menitam 27 is marker other traumatic	1	Joyce A. Dodson-D 20a. Method of Disposition			Box 18 F		ville,]		7250 tion - City or	Town State
Baltimore,	Ø 0		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State ceme	etery, cren	natory`or other place)	1				
altin	コモゼラ		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eureral Service Licens			en Cemetery Name and Address o		innich			, Maryland
m	Depared Depared Important in gence.		Jeor 11	Manne	_ 4:	l5 E. Wilso				1, Md.	
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.					rrest,		Approximate Interval Between Onset and Death
	Physician /Medical	r j	Immediate Cause (Final disease or condition resulting in death)	a. Cardia	_ ^ /	wholkin	in				2 47
	Examiner.			Due to (or as a consequent	ice of):	endere ?		Do			200
		ner	Sequentially list conditions, if any, leading to immediate salles. Enter Underlying	Due to (or as a consequen	ce of):						
	ecuter and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen		the					<u>ک</u> ری
68760,	icate be executed physician and s the burial-transit	al E		Due to (or as a consequent	ce or,						
687		edical									
Вох	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy			230	d. Date of deli	
ю. Ш	at the dea by the at tached fo	ysicl	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	n 5□	Other (specify)				Month	Day Year
Ф	res that thighed by be detac		Part II. Other significant conditions co	ntributing to death but not resultin	ng in the ur	nderlying cause given in	n Part I.	23e. Did t	obacco use	contribute to	the cause of death?
rds	w requires been sign should be	ed by	Diebets Mell	the Hope	10	moria		1 🗆 '	Yes 2□N	No 3□Pro	obably 4 9thknown
Records,	lawre as bee	Completed						24a. Was		24b. Were aut	topsy findings available completion of cause of
<u>=</u>		Con						perfo 1 Tes	rmed?	death?	2 □ No
Vital	Phyaicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		7		h (Check only o			
of		-	27. Manner of Death		b. Time of	28c. Injury at Work?		ome 5 Resi			cify)
ion	Attending death.	atlo	1 Accident 5 Pending investigation	(Month, Day Year)	Injury		2 □ No				
Division	or Attending after death. Diractor: After din by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (. City or To		lumber or Ru	ral Route Number.
			29a, Certifier 1 2 Certifying Phy	sician: To the best of my knowle	dge death	occurred at the time of	date and place	and due to the	rause(s) an	d manner as	stated
	To tha Hospital within 24 hours to the Funaral completely filled	edical		ner: On the basis of examination and manner stated.							
	To tha within 20 To tha R complete	×	29b. Signature and title of certifier	4.0		29c. License nu				igned (Month	
			- (2rtt 1)			D (80	, ()		「巨く	(3, 3	2005
-	5H-2		30. Name and address of person who co				MAGE	RSTO	wn	mo	21740
	Sta	te		32. Registrar's Signature							
L	Registi	ar	FEB 162	UUD Seeum D	· Pop	ye di					

			1- State of Maryland		artment of Health and I	Mental Hygier	ZIIII	06599
	Physici /Medic		1. Decedent's Name (First, Middle, Last) PAULINE MAE ARMENTL	001		FEBRUARY:	Day Year 2005	3. Time of Death
	Examir Funeral Director	er	4a. Fecility Name (If not institution, give street and number) \$\int \frac{5}{5} 9 \frac{1}{9} \frac{1}{10} \rho 7 \\ 5. Social Security Number 6. Sex 7. Age (In yrs. la 219-26-9151 10 M 21 F 66	ast birthday) Yrs.	4b. City, Town, or Location of Death AWC A II STOWN W If Under 1 Year III Under 24 Hrs. Months Days Hours Min.		4c. County of Deeth Sar) 9. Birth County 1938 Ma	no PF place (State or Foreign intry) ryland
	Maryland f show	lor		, Town or Lo indall:	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the I 23a or 28e- ast be notif	Funeral Director	10e. Street and Number 8809 Sigred Road		10f. Zip Code 21133		Citizen of What Cou	untry? us of America
036	filed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Items 23a or 28e-f show yth. The Medical Examiner must be natified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Amed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2(XNo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
21215-0036	i within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) UNK College (1-4or 5+) UNK	(Give life. L	dent's Usual Occupation kind of work done during most of work done during most of wor DO NOT use retired) Maker	king	. Kind of Business/li Own Home	ndustry
Maryland 2	should be filed and Mental Hyg s markad otha umatic evant,	To Be C	17. Father's Name (First, Middle, Last) Paul Dircks		Madeline	valentine	len Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic evant, the Medical Examinet must be notified at ODGE.		1 N Burial 2 Cramation 3 Demoval from State	8809 ace of Dispo	Sigred Rpad, Ran Sigred Rpad, Ran sition (Name of natory or other place) Cemetery 03/0	dallstown. Date 20c.		21133-4784 own, State
Baltir	permit. P Depertme Importan eny injur.		21. Signature of Funeral Service Licensee	22	h Alema and Address of Parilles	ring Byers	Funeral	Directors,In
8760,	be attending physicien and for use as the burial-transit	Ical Examiner	23a. Part T. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conse	ence of):	er the mode of dying, such as cardiac		JE .	Approximate Interval Between Onset and Death
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dead 9 ☐ Unknown	death 3□	Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year
	sign sign d be	by	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed 1 Yes 2 1	prior to co	opsy findings available ompletion of cause of
o	ding Ph J. After th funeral	ation; To Be		ER/Outpatien 28b. Time of Injury	t 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 2 esidence 28d. Describe how in		(ty)
Division	in the second	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)			28f. Location (Street City or Town, Sta	ate)	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Ortifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	on and/or inv	vestigation, in my opinion, death occu	rred at the time, date a	and place, and due t	to the cause(s)
B	5/6	7	30. Name and address of person who completed cause of death (Item 2	23a) (Type,	Print) S A ME Aparlia	Feb	EVARY 27	2005
	Sta Registr		31. Date filed (Month, Day, Year) 32. Register's Signatu MAR 0 1 2005	The M	Sparks + MAR	-4-15X	-11 7 BULL	21042

			For State Registrar		State o	f Marylai		artmer e <i>rtificat</i>				Mental Hy	/giene	005)	06600
	g		1. Decedent's Name (First, Mide	dle, Last)								2. Date of D	eath Day	. Yea	ır	3. Time of Death
	Physici /Medic					ert Eug	jene Ar	igel				TEBUR	47 7 2	1 20	205	4: 63 PM
	Examin	er	4a. Facility Name (If not instituti			()		-		Location			4c. 0	County of D	eath	•
			5. Social Security Number	6. Sex	ALTH	7. Age (In yrs		-	1 Year	MOR		8. Date of B	irth	N/A	Birthola	ce (State or Foreign
- 1	Funeral Director		218 36 6214		M 2□F	65	Yrs.	Months	Days	Hours	Min.	OCT. 6	193	9 N		h Carolina
	Pu ≱		Usual Residence of Decedent 10a. State 10b. Count	v		10c. C	ity, Town or I	ocation							100	d. Inside City Limits
	h the Maryland r 28a-f show notified at	or	Maryland N/A	,			Baltin									1 ∰Yes 2 □ No
	the ?	Director	10e. Street and Number				DATCI	10f. Zip	Code				10g. Citiz	en of What	Countr	y?
	h with	ai D	2024 Ramsey	Stree	et					21223	3			U.S.		
	oms 3	Funerai	11. Marital Status	1:	Armed Fo	edent Ever in I	U.S. 13	. Was Dece If Yes, spe	dent of Hi	ispanic Ori n, Mexicar	igin? (Sp	ecify Yes or N Rican, etc.)	0- 1-	4. Race - A Black, W		
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. In arked other than "natural", or items 23a or 28a-f show in marked other than "natural", or items 24a or 28a-f show unatic event, the Medical Examinating must be notified at	by Fu	1 Never Married 2 Ma 3 Widowed 4 Divorce		1 ∐Yes If Yes, Giv Year or D	2% No /e ates:		1□Yes		Specify:			1		Whi	
0	2 hou	ted !	15. Decede	ent's Educ	ation		16a. Dec	edent's Usu	al Occupa	ation			16b, Kin	d of Busine		
215	thin 7: e. an "n Medi	Completed	(Specify only high Elementary/Secondary (0-12)		College (I-4or 5+)		B kind of wo		iuring mos !)	t of work	ang				
2	ed will	Sol	Elementary/Secondary (0-12)				Li	aborer	:						rov	ements
pue	I be fil ntal H ed ott even	Be	17. Father's Name (First, Middle		· uil+.	on Ange	. 1			18. Moth		e (First, Middle ena Mid				
2	should nd Me mark matic	2	19a, Informant's Name/Relation			on Ange		ling Address	s (Street a	and Numb		rai Route Numi			в, <i>Zip (</i>	Code)
2	and 2 sealth ar n 27 is ner trau		Margaret Roge		siste	r	1	Twin				n Burni				
r.	item		20a. Method of Disposition	2 DD		20b.	Place of Disp cemetery, cr	oosition (Na ematory or	me of other plac	e)		Date	20c. Loc	ation - City	or Tow	n, State
į	Pages ment of ant: If it ury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		moval from		restlav	vn Men	Gar	dens		4/2005				le, MD
Baltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. I file 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examinational Department.		21. Signature of Funeral Service	e License	e Mand	wen						once Fu ay Bal				, P.A. and 21225
			23a. Part1. Enter the disease, shock, or heart failure. Li	or controlic	ations that o	caused the dea	ath. Do not e	nter the mo	de of dyin	g, such as	cardiac	or respiratory	arrest,		1	Approximate nterval Between
	Pnysician		Immediate Cause (Final disease or condition		1)		ricu			TAC	41	CAND	IA		(Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):									
		P.	Sequentially list conditions,	b.		(or as a conse	iquence of).								+	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	【 。												
_	cate be executed by sician and the burial-transit	Exa	resulting in death) Last	Ü.	Due to	(or as a conse	quence of):				-					
8760	ate be physicia the bu	dicai		d.												
Œ	entifica ding place as 1	Med	IF FEMALE:	22	le If was our	tcome of pregr	22001									
S.	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	2.0	1 Live b	ointh 2 ☐ Fei nant at time of	tal death 3	□Ectopic p					2.	3d. Date of o Month		/ Day Year
C	the d	hysi	1 □ Yes 2 □ No 9 □ Unknown		9□ Unkn	own										
1GEL, WILKER!	The law requires that the death certific the law requires that the death certific the las been signed by the attending page 2 should be detached for use as		Part II. Other significant condi	tions cont	tributing to d	eath but not re	sulting in the	underlying	cause give	en in Part I						cause of death?
BEN	equir equir	Completed by	<u> </u>	- P 8	6		11					1	Yes 2	No 3□	Probal	oly 4 Aunknown
200	has b	npie		ird	1000	yopa	lhy					24a. Wa auto	s an opsy formed?	24b. Were prior to death	autops to com	sy findings available of cause of
77	r. The					<i></i>						1 ☐ Yes	2 No	1 🗆 Y	es 2	□ No
3 \$	Physicien: The lave this certificate has ral director, page 2) Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☒ No		ospital:	Inpatient 2[☐ ER/Outpati	ent 3 D	Othe	or.		th (Check only ome 5 - Res		□0th== /0		
~ "	Phy er this	n: To	27. Manner of Death		28a. Date		28b. Time		28c. Injun Worl		irsing ne	28d. Describe			pecity)	
7 5	ath.	atio	E LI Accident	stigation	(MOI)	iri, Day 18ar)	Injury	М		Yes 2	No					
S is	r Atte	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be rmined	28e. Place build	of Injury - At ing, etc. (Spec	home, farm, s	street, factor	y, office				(Street and own, State)	Number or	Rural	Route Number,
30	oital o															
A	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical			er: On the b							and due to the red at the time				
	Fo the within Fo the comple	Me	29b. Signature and the of centr	Ter						e number				signed (Mo		*
	1		> Slow	M		MO	1	(2	000	61	16.	5	TEB!	4427	12	1st 2005
	6		30. Name and address of person		mpleted cau	se of death (Ite	эт 23a) (Тур	e, Print)				Timon				
X ^M	., St	ate	31. Date filed (Month, Day, Yea	ir)	32	Registrar's Sign	nature						- t			
	Regist	rar	MAR 0 1	2005) Da	SE ILE	18 A	man!	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Mary		artment of F rtificate of I		, ,	ene ı. No.	
	Physici /Medic		Decedent's Name (First, Middle, Last)	Albert B.	Adams			2. Date of Death Month February	26 200	3 Time of Death
	Examin		4a. Facility Name (If not institution, give s North Arundel H			_	r Location of Death Burnie	1	4c. County of Do	eath
	Funeral Director		233 24 4404	7. Age (In 1M 2 F 82	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) June 19,	^{'ear} 1922 N	Birthplace (State or Foreign Country) Worth Carolina
	aryland show	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits
	he Ma	ecto	Maryland Anne Ar	undel	Glen Bu					1 ☐ Yes 2 🙀 No
	a or 3	i Dir	7466 Furnace B	ranch Rd. A	ot. 318	10f. Zip Code	1060	10g	J. Citizen of What U.S.	Country?
ဖွ	after death or Itams 2.	Funeral Director		12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		mencan Indian, hite, etc.
8	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW	7 II	1 ☐ Yes 25€ No	Specify:		Specify:	White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be natified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of world)	king 16	b. Kind of Busine	,
	filed v Hygie other t		17. Father's Name (First, Middle, Last)		II	uck Drive		ne (First, Middle, Ma		ng Company
Maryland	uld be dental rked c	To Be	Nebra	ska Adams			Estel			available)
lary	2 shou and N la mai		19a, Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number, C	City or Town, State	o, Zip Code) 21060
	tealth im 27 her tr			wife	7466	Furnace I	Branch Ro			Burnie, MD
Baltimore,	ages nt of h t: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re			esition (Name of matory or other place Crematory			c. Location - City	
틅	nit. Partme ortani injury		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Aricense			-	,			, Maryland
Ä	permi Depa Impo any ir		Pleno (UL	mage	4	001 Ritch	nie Highw	nce Funer ay Balti	more, Ma	ryland 21225
	è.		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final			er trie mode or dyin	ig, such as cardiac	or respiratory arrest	ι,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor						
4	Examiner		Sequentially list conditions b.							
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	nsequence of):					
	xecute and al-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):					
68760,	tificate be executed ig physician and as the burial-transit	edicai E	U d							
	rtificat ng phy as th		IC COMAL E.							
.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (s <i>pecify)</i>			23d. Date of o Month	delivery Day Year
Δ.	that the poly detact	by Ph	Part II. Other significant conditions con-	tributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
rds	v requires been signi should be	ed b			<u></u>			1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
Vital Records,	fhe law requie has been age 2 should	Completed						24a. Was an autopsy performe	d? prior t death	
ta	ian: ' irtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dear	1 ☐ Yes 24Z th (Check only one)	INO ILIY	es 2 No
of <	Physician: r this certific ral director,	၉	1 ☐ Yes 2 ☑ No		2 ER/Outpatien	at 3□ DOA Oth	er: 4 🗆 Nursing He	ome 5 Residenc	e 6 □Other (Sp	pecify)
Division o	ding Afte fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Wor		28d. Describe how	injury occurred	
DIX	in Sire	Certifi	4 Homicide determined	28e. Place of Injury - building, etc. (Sp	pecify)			City or Town, S	State)	Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funaral Diract completely filled in by	edical	29a. Certifier (Check only 2 Medical Exemin	sician: To the best of my ner: On the basis of exa- and manner stated.	y knowledge, death mination and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	With To t	Σ	29b. Signature and title of certifier			29c. Licens			. Date signed (Mo	
F .	11			-a see hun			5597	3 Fe	bruary	26,2005
V	11		30. Name and address of person who cor 2010/00 Desse	11500	Sutherla	nd Hill	Nau (alver spr	ing M	0 20904
4	Sta Registr		31. Date filed (Mark Day Year) 2005	Registrar's S	Signature And	will!			· · · · · · · · · · · · · · · · · · ·	

		St State Registrar	ate of Maryla	-	rtmen tificate				Reg. No	UU	a design	06602
Physician /Medica	ıl .		thur R. A	dkins	Ab Cib.	Tours or	Location of	2. Date of De Month Februal	ry 2	20 County o		3. Time of Death 12:42 P. M
Examine		4a. Fecility Name (If not institution, give street 257 Rupert Circle		look birtholous		Balt	Location of imore			Anne	Ar	undel
Funeral Director		5. Social Security Number 220 36 1296 6. Sex 1 🗵 M		. last birthday) Yrs.	Months	Days	Hours	Min. (Month, D.	y, Year)	42	Wes	place (State or Foreign intry) t Virginia
Maryland	tor	10a. State 10b. County Maryland Anne Aru		city, Town or Lo Saltimor								10d. Inside City Limits 1 ☐ Yes 2 ☆No
h with the	Funeral Director	10e. Street and Number 257 Rupert Circle			10f. Zip	Code 2122	25			U.S.	nat Cou	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Itama 23a or 28a-f show any injury or other traumatic event, tre Medical Examinar must be notified at once.	d by Funer	1 Never Married 2 Married 1 3 Widowed 4 Divorced	Vas Decedent Ever in med Forces? ☐ Yes 2 No Yes, Give ear or Dates:		1 □ Yes	2 ∑ No	Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Black, Specify:	White Wh:	ite
21215-0036 d within 72 hours alt glene. er then 'natural', or , tre Medical Exert	Completed by	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12) 12th		life. I	dent's Usua kind of wo DO NOT us ster r	rk done d se retired	turing most)	of working	16b. K	ind of Bus		ndustry g Company
Maryland 212: d 2 should be filed withir th and Mental Hyglene. 77 is marked other then traumatic event, Italia	To Be C	17. Father's Name (First, Middle, Last) Charles Sego						r's Name (First, Middle Gladys		(no	t a	vailable)
e, Mar 1 and 2 sh Health and 6 m 27 is m		19a. Informant's Name/Relationship (Type, F Andrew Bisaha 20a. Method of Disposition		1622	Lyle	e Cou	ırt	Parkville Date	≥, Ma	ryla	nd :	
Baltimore, sermit. Pages 1 a Department of Hec mportent: if item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	val from State	yview C	Cremat	cory		3/3/2005 Gonce Fur	Bal	timo	re,	Maryland
Deam Permi P	a to	2 a. Part1. Enter the disease, at complication shock, or heart failure. List only one ca	mutual ns that caused the decuse on each line.	Li 140	01 R	itch:	ie Hig	phway Balt	imor			land 21225 Approximate Interval Between
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Chronic Due to (or as a conse Smokic Due to (or as a conse	equence of):	struc	tive	- K	ulmonar	<u>y T</u>	Disec	ise	onset and Death 10 yrs > 40 yrs
176(ca	in the past 12 months?	Due to (or as a conse	nancy tal death 3	Ectopic pr					23d. Date Mont		very Day Year
cords, P.O. Box 687 wequires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Med		Unknown		, ,	ause give	en in Part I.					the cause of death?
The law recate has be page 2 sh	Comple	J					-	24a. Was auto perf 1 🗆 Yes		pri	ere aut ior to c ath? Yes	opsy findings available ompletion of cause of
on of Vi	ation: To Be	2 Accident investigation	tal: 1 ☐ Inpatient 2 (Ba. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		8c. Injun	er: 4 🗆 Nui	of Death (Check only sing Home 5 Res 28d. Describe	idence			ify)
Ts start and sta	Certification:	4 Homicide	Be. Place of Injury - At building, etc. (Spec	cify)				City or To	wn, State)		ral Route Number,
the Host tin 24 hor the Funa	Medical		n: To the best of my ki On the basis of examinand manner stated.	nowledge, deatl	vestigation	, in my o	pinion, deat	d place, and due to the h occurred at the time	, date and	1 place, ar	nd due	to the cause(s)
To To Con	Z	29b. Signature and title of cedifier	34		J.	D (005(0325	29d. Da	te signed $2/2$	Month 5	Day, Year)
2		30. Name and address of person who complete Fri Ka	1. Kane	IM, S	No.	37	00	ATH St.	B	alto	1.0	ND 21225
Stat Registra		31. Date filed (Month, Day, Year) MAR 0 1 2005	32. Registrar's Sig	nature Las	Les .							

ORIGINAL

	1- State of Maryland / Department of Health and Mental Hy Certificate of Death	giene 005 06603
Physician /Medical	1. Decedent's Name (First, Middle, Last) Edgar Donovan Anderson 2. Date of Dimension 0.2	
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Bi (Month, D. Feb. 9.	Harford Additional Property of the April 1916 State of Foreign Country) Harford 9. Birthplace (State of Foreign Country) North Carolina
with the Maryland a or 28e-1 show the notified at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Virginia Stafford Stafford	10d. Inside City Limits 1 Ž Yes 2 □ No
ath with the Maryla sage or 28a-1 shown the notified at the Indiana at the Indiana at In	10e. Street and Number 10f. Zip Code 21 Maple Lane 22556-1244	10g. Citizen of What Country?
tems tems	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forcas? 1 Never Married 2 Married In Marital Status 1 Never Married 2 Married If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No Specify:	Coccity
21215-0036 ed within 72 hours afte ygiene, grethen "natural", or in t, the Madical Exemin Completed by Fi	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WW 11 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Maryland 21: d 2 should be filed wit in and Mental Hygien it? Is marked other the traumatic event, the	10 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)	
should I sho	Frank (unk) Anderson Minnie (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numb	
Ore, Mi	Donald R. Anderson, Sr Son 21 Maple Lane, Stafford, Virgonal Method of Disposition 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	
Baltimore, permit. Pages 1 a Department of Her Important: If Item any injury or othe	'4 Donation 5 Other (Specify) Bel Air Mem. Gardens 2-28-05	Bel Air, Maryland Funeral Home, P.A.
68760, tificate be executed The principle of the principl	23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	rrest, Approximate Interval Between Onset and Death
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the the completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
w requires that been signed be should be deta		obacco use contribute to the cause of death? Yes 2 \(\subseteq No \(3 \subseteq \text{Probably 4 \(\frac{\mathbf{X}}{2}\)Unknown
sician: The law requires certificate has been sirector, page 2 should	1 Yes	psy prior to completion of cause of death? 2√CX\square 1 ☐ Yes 2 ☐ No
Ing Phy Miter this uneral d	examiner? 1	dence 6 Other (Specify) how injury occurred
UNISIC Hospital or Attand Hospital or Attand 24 hours after death Funeral Director: / telly filled in by the f lical Certificat	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier	
To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manyer stated.	date and place, and due to the cause(s)
	29b. Signature do title of certifier 29c. License number D40723	29d. Date signed (Month, Day, Year) February 23,2005
State	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karithanom Isaac, M.D., VA Maryland Health Care System 31. Date filed (Month, Day, Year) 32. Registrat's Signature	m,Perry Point,MD
Registrar DHMH 17 Rev 1/2001	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 1 2005	

ORIGINAL

		Please	State of Maryla				•	•	
		1 - State Registrar		Cei	rtificate of	Death	Re	g. No.	
		1. Decedent's Name (First, Middle, Lasi)				2. Date of Death Month	Day U U Year	3. Time of Death
Physic /Med		Loretta	a I. Anzalone				Feb. 28	, 2005	2:17 A M
Exam	iner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	ath
		Oak Crest Care Ce		land hinth days	If Under 1 Year	arkville If Under 24 Hrs.	8. Date of Birth		imore
Funera Directo		,	M 2⊠F	s. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day,		rthplace (State or Foreign country)
		Usual Residence of Decedent		92			Dec. 13	, 1912	Maryland
rylan		10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits
ith the Marylan or 28e-f show	Director		imore		Parkvi	ille			1 ☐ Yes 2 🖾 No
with th		10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
eath y	Funeral	8832 Walther Blv	12. Was Decedent Ever in	U.S. 13		21 234 Iispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Am	erican Indian
fter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
urs a	þ	3 ☐ X Vidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√√No Specify:			Specify: White	
If I I I I I I I I I I I I I I I I I I	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of work	ing	6b. Kind of Business	s/Industry
Mithin Ne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			
Hygie thert		11 17. Father's Name (First, Middle, Last)			Homemak	18. Mother's Name	e (First. Middle. M	<u>0ω⊓ Hc</u> faiden Sumame)	me :
d be ontail sed o	To Be	Milto Alexa	ander Platt				ta Agnes		
Lat y idnitice Z. I.Z. 13-0000 2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked other than "natural", or items 23a aumatic event, the Modical Examiner must it	F	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)
ite, IVIDITY INTERFECTIONS STANDS AND AND AND AND AND AND AND AND AND AND		Mr. Thomas W. Anza	lone/Son	6 Ra	inflower	Path #103	3 Sparks	. Marylan	d 21152
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is		20a. Method of Disposition	20b.		sition (Name of matory or other place			20c. Location - City o	
Pages tment of the first of the		1 ⊠ Burial 2 □ Cremation 3 □ i '4 □ Donation 5 □ Other (Specify)		st Holv	Redeemer	Cem. 3	/3/05 E	Baltimore,	Maryland
permit. Departr Importe any inju	ouce.	21. Signature of Funeral Service Licens	9/201	22	2. Name and Addre	ss of Facility Ruc			Home, Inc.
4 70 E 2 6	OI .	michael	1 Thurs	1	050 York	Road Tou	uson, Mar	cyland 212	
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	ne cause on each line.	ath. Do not ent					Approximate Interval Between Onset and Death
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	a. Advance	_00	Alzh	eimer 13	Diseus	e	
Examine			Due to (or as a conse	equence or):					
	je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	equence of):					
cuted nd ransit	Examiner	that initiated events	С.						
te be executed ysician and he burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
ficate b physic ts the b	dical	•	d						
death certificate be attending physical of for use as the key	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregi	nancy				22d Date of de	di san
atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 [Ectopic pregnancy Other (specify)	1		23d. Date of de Month	Day Year
the d	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
s that	by P	Fait II. Other significant conditions co		esulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
w requires to been signer should be	ed	acrtic st	enosis				1 🗌 Ye	s 2. ∑M o 3□P	robably 4 Dunknown
law ras be	ple	Broast Con	seex pos	+ 100	mpecto	my	24a. Was an	prior to	utopsy findings available completion of cause of
The The	Completed		`			3	perform 1 Yes 2	ed? death?	s 2 No
clen: certifica	Be	25. Was case reterred to medical examiner?	Hospital:		Oth	26. Place of Deat			
Phys this ral dir	P.	1 Yes 2 No	28a. Date of Injury	ER/Outpatier	IL SLIDUA	4 A Nursing no	me 5 Resider	nce 6 Other (Spe	ecify)
iding Phy th. : After this	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2□No			
Atter dea ector	Ifice	3 Suicide 6 Could not be determined	288. Place of injury - At	home, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,
s after saling	Certification:	4 Hollicide	building, etc. (Spec	эну)			City of Town,	State)	
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit	edical		vsicien: To the best of my kr iner: On the basis of examinand manner stated.						
To the Hospital or Attending Physicien: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Mec	29b. Signature and title of certifier	and mainer stated.		29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
6		a mon	iero		0581	646	F	ebruary	28, 2005
10		30. Name and address of person who co			Print)			,	
V	****	Anna Monias 31. Date filed (Month, Day, Year)	32. Receivar's Sin	nature.	300/00asc)	, Parkv.1	10,41	21234	
Regis	State strar		\$ 800 Walt 32. Regentrar's Sign 2005	J. J.	grave				

DHMH 17 Rev 1/2001

MAR 0 1 2005

Anzalono, Lore HG

				State of Manyland / Di	epartment of Health and N	-	_	
					Certificate of Death		2005	06605
				Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
		Physici /Medic		Mary Ruth Brazil		Februar	y 25, 2005	1806 M
		Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
				Upper Chesapeake Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Bel Air	8. Date of Birth	Harford	
		Funeral Director		01/ 00 0/01	rs. Months Days Hours Min.	July 6,	1926 Mary	place (State or Foreign ntry) 7 Land
		pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town				10d. Inside City Limits
		Aaryla Febov	ō		Bel Air			1 ☐ Yes 2 ☐ No
		1 the h	rect	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
.9		within 72 hours after deeth with the Maryland ene. than "natural", or items 23a or 28e-f ehow than Madical Expirit et must be multibud at ha Madical Expirit et must be multibud at	Funeral Director	2359 Conowingo Road	21015		U.S.A.	
0		tems tems	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
00	36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give 3 😾 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	nite
	9-0	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work	ina 1	6b. Kind of Business/Ir	dustry
	21	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		antique sho	nn.
	2	i filed withir I Hygiene. other then rent, the M		12 years	owner	e (First, Middle, M		
ſŨ	au	id be in ked o	To Be	Harold Carroll		eonard	,	
0	ary	12 should be filed v n and Mental Hygie 7 is marked othar t raumatic event, In	-	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Rur 18 Drytown Road, Hol	al Route Number,	City or Town, State, Zij	Code)
13	Š	1 end 2 Health ar em 27 is			The second secon			
02/25/05	Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked othar than "naturat", or items 23a or 28e-f ehow amy injury or other traumatic event, the Medical Examinating must be notified at once.		TEX Bullar 2 Cremation 3 Chemioval nom State Tr = 1 A.4	Disposition (Name of crematory or other place) r Mem. Gdns. 3/1/	- N	oc.Location-City or T Bel Air, Mc	
0	i	nit. Paratme orteni injury		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility			
	ä	permit. Departr importe any inje	lo :	Buen G. Weller	Schimunek Funera 610 W. MacPhail	1 Home o Road, Re	f Bel Air, 1 Air. Md.	Inc. 21014
				23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition Chrimic Obs	Tructive Lung	1) isease		Onset and Death
2		/Medical Examiner		resulting in death) Due to (or as a consequence of	/): /			/
5		_	Jer	Sequentially list conditions, if any leading to in redule cause. Enter Undertying Cause (Disease or injury	j:			
CA.		cuted nd rransit	Examiner	that initiated events c				
3	760,	e be exacuted /sician and e burial-transit		resulting in death) Last Due to (or as a consequence of):			
0	387	physicate to physical street.	dlcal	d				
Mylizen	Box 687	eath cartificate be exacu attending physician and for use as the burial-tra	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	• -		23d. Date of deliv	ery
见。		the atte	sicia	in the past 12 months? 1 Yes 2 No 1 Here at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
20	P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying enurs sives in Red I	23a Did taba	acco use contribute to t	ha causa of death?
(20)	ds,	w requires that the sbeen signed by t should be detach	d by	Alchemers disease	the diluentying cause given in Fatti.	1		pably 4 Unknown
	cor	The law requires that the death the has been signed by the atter bage 2 should be detached for u	ompleted	cornery artery disease		24a. Was an	24b. Were auto	ppsy findings available
	Re	ician; The lav certificate has ector, page 2	ome	hypertensin		autopsy perform	prior to co ed? death? XNo 1 ☐ Yes	mpletion of cause of 2□ No
+	ital		Be C	25. Was case referred to medical	26. Place of Deat	h (Check only one		
0	of <		2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ npatient 2 ☐ ER/Outp		me 5 Residen	ce 6 Other (Special	(y)
MC# 118297+ Division of Vital Records, the Hospital or Attending Physician: The law requires the Funeral Director: Affer this certificate has been signed proposed from the funeral director, page 2 should be a found to the funeral director. Page 2 should be a found to the funeral director.				27. Manner of Death 1 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Inj	vinjury occurred			
00	Visl	Atten	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	et and Number or Run	al Route Number,
#	٥	ital or rs afte ret Dir led in		Troined Building, etc. (Opecny)		ony or 7 onn,		
F		To the Hospital or Attending Phys within 24 hours after death. To the Funeret Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one)	for investigation, in my opinion, death occur	red at the time, dat	e and place, and due t	o the cause(s)
\$		To the within 2 To the complet	Mec	29b. Signature and tipe of certifier	29c. License number	296	d. Date signed (Month,	Day, Year)
		->	-	Asperut mo	00047631		2/25/03	5
	17	77		30. Name and address of person whi completed cause of death (Item 23a) (T	ype, Print)	,	DIA	
ſ				Antoinette Speretz MD 500 31. Date filed (Month, Day, Year) 32. Regis ar's Signature	Upper chesupeake e	DRIVE.	Del Mir n	1)
		StaRegisti	9	and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (The state of the	: parte			

State

Registrar

111 Penn Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

The BONE Miking

MAR 01

Date filed (Month, Day, Year)

FEBRUARY 23, 2005

Baltimore, Maryland 21201

			1 - For State Registrar		partment of Health and It ertificate of Death	Mental Hygiei	2000 0000	7	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Eva		Bivens	2. Date of Death Month	Day Year 3. Time of De 23 2005, 3.22		
	Examin	_	4a. Facility Name (If not institution, give st Stella Maris Ho	· ·	4b. City, Town, or Location of Death Baltimore		4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthda M 2XIF 85 Yrs.		8. Date of Birth O1 26	9. Birthplace (State or Fo	reign	
	Maryland f show	lor	Usual Residence of Decedent 10a. State 10b. County M.D. N.A.	10c. City, Town or Baltimo			10d. Inside City L XIXYes 2		
	with the	Direct	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?		
036	be filed within 72 hours after death with the Maryland stal Hygiene. d other than "natural", or Itams 23e or 28e-f show event, The Medical Exerting Frast Re Incilliad at	by Funeral Director	2203 Dukeland St 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced		21216 B. Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerton 1 □ Yes 2 ▼ No Specify:	pecify Yes or No- p Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	filed within 72 ho Hygiene. ther than "natur int, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade	Completed) (Given life College (1-4or 5+)	sedent's Usual Occupation re kind of work done during most of work DO NOT use retired) ift Shop	king 16b	. Kind of Business/Industry		
nd	should be filed withir and Mental Hygiene. It marked other than umatic event, the M	To Be C	17. Father's Name (First, Middle, Last) John D. Fairclo		18. Mother's Nam	ne (First, Middle, Maid Stewart			
	3 8 8 5		19a. Informant's Name/Relationship (Type) Frances Lee Buni	I consume	iling Address (Street and Number or Ru Garden Street,				
Baltimore,	Page ento nt: If ry or		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State 20b. Place of Dis	position (Name of ematory or other place) Memorial Park	Date 20c.	. Location - City or Town, State		
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	xek #	22. Name and Address of Facility arch F/H West 300 Wabash Ave,		re, Md 21215		
	Physician /Medical		23a. Part J. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.		or respiratory arrest,	Approximate Interval Batwee Onset and Dea	n n	
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of): Due to (or as a consequence of):					
68760,	icate be executed physician and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of):			£8		
.O. Box 6	death certif e attending d for use a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year		
Δ.	The law requires that the te has been signed by the rage 2 should be detached.	by	Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably		
Vital Records,		Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 Yes 2		lable of	
of	ding Phy: h. After this funeral di	ition: To Be	2	examiner?	spital: 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Cther: 4 Nursing H	th Check only one ome 5 Residence 28d. Describe how in	6 Øother (Specify) hospic	<u>e</u>
Division	i jite	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)		
	To the Hospital or within 24 hours atted within 24 hours atted To the Funeral Direction completely filled in I	edicai (29a. Certifier Certifying Physical (Check only one) 2 Medical Examin	cian: To the best of my knowledge, dear: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)		
	To th withir To th	Me	29b. Signature and title of detrifier	7	29c. License number	29d. I	Date signed (Month, Day, Year)		
	5		30. Name and address of person who com		aul Pl Baltime	ne md.	21202		
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 1 200	82. Egistrar's Signature	pole		Citot		

Physician /Medical Examiner	1 - State Registrar 1. Decedent's Name (First, Middle, La: ### Time			2. Date of	Death 3, Time of Death
Examile	4a. Facility Name (If not institution, giv	Bevar and number)	22 S 4b. City, Town, or	Month Feb Yul	Day Year 7 1151
Director	5. Social Security Number 218–03–7902	Jursing Hon	last birthday) If Under 1 Year Months Days	Himere If Under 24 Hrs. 8. Date of Hours Min. (Month,	Baltimore Birth Day, Year) 0/1905 Birth Pennsylvania
show	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location		10d. Inside City Lim 1 ☐ Yes - 2 X 〕
or 28e-f	MD Baltin 10e. Street and Number	ore pa	altimore 10f. Zip Code		10g. Citizen of What Country?
within 72 nours after death with the maryland then "naturel", or litems 23a or 28e-1 show the Medical Examinar must be notified at the modified by Funeral Director mipleted by Funeral Director	5110 McFaul Road 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1	21206 3. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify:	Black, White, etc. Specify:
s 1 and 2 should be lined within 72 hours after load if Health and Mental Hyglene. Item 27 is marked other then "naturel", or Items other treumatic event, the Medical Examinating To Be Completed by Funer	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation	16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired) Homemaking	uring most of working	White 16b. Kind of Business/Industry Own Home
nd Mental Hygis marked other marks event, II	17. Father's Name (First, Middle, Last Charles Harrymar 19a. Informant's Name/Relationship (1		18. Mother's Name (First, Mid Bertha Marchb nd Number or Rural Route Nu	
permit. Fages 1 and 2 should be into Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event one.	Christa A. Jone 20a. Method of Disposition 1 X Burial 2 Cremation 3 Cremation 5 Other (Special Signature of Funeral Service Lice	Removal from State (5)	Place of Disposition (Name of cemetery, crematory or other place John's Ch. Cem 22. Name and Addres	. 02/19/2005 s of Facility E. F. La	20c. Location - City or Town, State
death certificate be executed x x x x x x x x x x x x x x x x x x x	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	quence of):		
the deam cerming the attending ched for use as system/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms of the continuous forms of	al death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
es in se di gue	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause give	1	id tobacco use contribute to the cause of death Yes 2 No 3 Probably 4 Monkm
The law ate has b page 2 st	Plententa Pnomica 25. Was case referred to medical				utopsy prior to completion of cause death? ss 2 No 1 Ves 2 No
hys his his I di	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation		28b. Time of 28c. Injury Work	4 Muising Home 5 H	esidence 6 Other (Specify) be how injury occurred
itel or rs afte rel Dir led in		City or	Location (Street and Number or Rural Route Number, City or Town, State)		
he Hospitel in 24 hours a he Funeral pletely filled edical Ce	(Check only 2 Medical Exa	hysician: To the best of my known iminer: On the basis of examination and manner stated.	ation and/or investigation, in my or	pinion, death occurred at the tir	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier	aw mo	29c. License 2005		29d. Date signed (Month, Day, Year) Feb 17th, 2005
1	30 Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print) Loch Raver	0/1/2	Feb ,7th, 2005 fimore, MD 21239

			For State Registrar				d / Depa		t of H	ealth a		lental Hy		0.0	5	06609	
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ı	Funeral Director		219-18-6257	5. Sex 1 □ M 2 □		79 (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	Il Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 4/9/19	rth ay, Year) 925			nplace (State or Fore untry) RYLAND	ign
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD BAL'. 10e. Street and Number	TIMORE		10c. Cit	y, Town or Lo		Code				10g. Citi	izen ol W	Vhat Co	10d. Inside City Lim 1 Yes 2 X	
	3a or	al Dir	8415 BELLONA LA	ANE A	т. 9	11		101. 210	2120	04				JSA	viiat Co	unity :	
	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. The filem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2□Marrie 3 □ Widowed 4 □ Divorced	d 1 []	Decedent ed Forces? Yes 2 X s, Give r or Dates:	?	1	Vas Deced f Yes, spec 1 ☐ Yes		ispanic Ori n, Mexicar Specify:	gin? (Sp. i, Puerto	ecify Yes or N Rican, etc.)	0-		k, White	ncan Indian, a, etc. ITE	
2.12.13	od within 72 ho giene. er than "natur , the Madical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12TH GRADE	grade comple	eted) ege (1-4or	5+)		dent's Usua kind of wor DO NOT us RETAF	rk done d se retired	ation during mos	t of work	ing		nd of Bu			
yland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M.	To Be (17. Father's Name (First, Middle, L MAURICE O'CON							18. Mothe		e (First, Middle NN	a, Maiden	Surnam	e)		
	and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationsh JOHN G. BAUBLIT			AND		_				al Route Numb • 911	oer, City o			(ip Code) 21204	
נים	permit. Peges 1 and 2 Depertment of Health s Important: If Item 27 it any Injury or other tra		20a. Method of Disposition 1 Derial 2 Termation			20b. F	lace of Dispo	sition (Nan	ne of			Date		•		Town, State	_
	t. Pege tment tant: If		* 4 □Donation 5 □ Other (Sp	ecify)	from State			EMATO								E, MD	
ם ם	Depending of the pool of the pool once.		21. Signature of Funeral Service L	censee								JOHNS(VD. TO				OME, P.A. 286	
	Physician /Medical /Medical	dicai Examiner	d													Approximate Interval Between Onset and Death	
O. BOX 9	The law requires thet the deeth certifical site hes been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	10	s, outcome Live birth Pregnant a Unknown	2 Feta	I death 3	Ectopic pr Other (sp						23d. Dat Mor		very Day Year	
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מו חפכם	The lar	Completed										1 ☐ Yes	opsy ormed? 2 No	5	Vere au prior to d leath? Yes	topsy lindings availate completion of cause of 20 No	ole of
5	Physician: this certific al director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	1 Nnpati	ent 2	ER/Outpatier	it 3 DC	Othe	or		n <i>(Check only</i> me 5□Res		6 □Othe	er (Spec	cify)	
JIVISION OF	To the Hospital or Attending Physician: whilm 24 hours lefter death To the Funeral Director: Atter this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig. 3 Suicide 6 Could n	ation	Date of Inju (Month, Da	ay Year)	28b. Time o Injury	М		yat k? Yes 2□	No	28d. Describe					
	ital or Ati		4 Homicide determin	ned 28e.	building, e	tc. (Specif						City or To	wn, State)		ral Route Number,	
	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical E	xaminer: On	To the best the basis of manner st	of examina	owledge, death	vestigation	, in my of	pinion, dea	nd place, ith occuri	and due to the ed at the time	, date and	place, a	and due	to the cause(s)	
1.	Twill Co.	A .	29b. Signature and tifle of certifier 30. Name and address of person v	no completed	Cause of	death (Iter	n 23a) (Type.	D	256	e number				-, 2		1, Day, Year) 05	
Ú	Sta Registr		31. Date filed (Month, Day, Year)				The state of the s		orano estano esta	102W	4 ME	RYLAN	D 21	204	*		
DM	MH 17 Pov 1/2	-	MARUI	2005	NEW	-											_

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year 9.53 an BURNS WILLIAM 22nd 20057 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Overlea
5. Social Security Number 6. Sex 7. A Baltimore City
9. Birthplace (State or Foreign
Country) Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F Hours Months Days Director 69 212-34-4099 Usual Residence of Decedent 02/07/1936 MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Heatth and Mental Hyglene.
ant: If Item 27 is merked other than "netural", or items 23e or 28e-f show unt: If Item 27 is merked other than "netural", or other traumatic event, the Medical Examiner matics neglial at uny or other traumatic event, the Medical Examiner matics neglial at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 📉 No Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3117 Dubois Avenue
11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 Yes, Giver Year or Dates: Funeral 21234

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States
14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0020 1□Yes 2XNo Specify: Completed by Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Optical Optician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Edward Lawrence Burns Margaret Florence Tilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Thiess/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location · City or Town, State 20a. Method of Disposition Department of himportant: if ite any injury or of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 26 Chesapeake Crematory Inc. 2005 Beltsville, Maryland 21. Signature of Funeral Service Licensee M00986 Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

8717 Green Pastures Drive Baltimore, Maryland 21286

Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final · Atherisclentic Cardiovascylar Disease disease or condition resulting in death) Examiner Examine or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical resulting in death) Last Due to for as a consequence on: use cate has been signed by the a page 2 should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown è Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 21/2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

45 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 25 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural after death. 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours after de: To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 201-109 Back River Neck Rd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MAHMOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene	95	0661	
Certificate of Death			

		•	State Registrar		Cer	tificate of l	Death	Reg.	. No.	
X.	Physici /Medic		1. Decedent's Name (First, Middle, La NOBUKO W	V. BROWN	,		"	2-Date of Death Month	Day 17 Year 25 2005	3. Time of Death 11 · 3 / p · M
3	Examin		4a. Facility Name (If not institution, giv			Randa11		V	4c. County of Death Baltimore	
	Funeral Director		070 40 4434	ים יים	(In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	Hours Min Ja	8. Date of Birth (Month, Day, You inuary 21	9. Birthp Coun 1933 Jaj	lace (State or Foreign try) pan
	death with the Maryland me 23s or 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number		10c. City, Town or Loc Baltimore			10g	. Citizen of What Coun	0d. Inside City Limits *XXYes 2 □ No try?
	th with		3910 Fallstaff	Road		21215		Uni	ted States	Of America
	be filed within 72 hours efter death with the Marylan dal Hygliene. All Hygliene death and instinction of the than and instinction of the marked Examination of the marked at a seent, the Marked Examination of the marked at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Midowed 4 ☐ Divorced	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A X Year or Dates:	lf If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6 Specify: Japa	etc.
1215-0036	within 72 h ene. than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+	(Give k	ent's Usual Occupi kind of work done o DO NOT use retired	during most of work f)	ing	b. Kind of Business/Indo	
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ге, маг	Health and Notes that I health and Notes that I had I had I had I hear treumal		19a. Informant's Name/Relationship (Mrs. Valerie Gif 20a. Method of Disposition 1 XX urial 2 Cremation 3 C 14 Donation 5 Other (Specie	fon	112 Ki	ing Fores	t Lane, N	Newport No	ews, Virging Location - City or To	nia 23608 wn, State
saltimore,	permit. Pages Department of Importent: If I eny Injury or once.	ĺ	21. Signature of Funeral Service Lice	nsee	22.	Name and Addres	ss of Facility Lor	ing Byer	ings Mills, s FuneralDi town,Md 211	irectors,In
	eath certificate be executed Example (Among physician and for use as the burial-transit	Medical Examiner	23a. Pan. Enter the disease, or common shock, or heart failure. List only shock, or heart failure. List only shock, or heart failure. List only shock and the seaso or condition resulting in death) Sequentially list conditions, fary, Learns to innectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	he death. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Batween Onset and Death 10 mg to the Start Interval Batween Interval Bath Interval Bath Interval Bath Interval Bath Interval Bath Interval Bath Interval Bath Interval Bath Interval Bath Interval Bath
O. BOX 6	D 0 D	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□ Unknown	! ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
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DIVISION	el or Attending F s after death. Il Director: After In by the funer	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
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	Som Som	2	29b. Signature and title of certifier	raph r	10	29c. License	4288		Peliment, E	25 2001
/	10/		30 Name and address of person who	completed cause of dea	ath (Item 23a) (Type, F	Print)	grital a	enter	U	
	Sta Registr		31. Date filed (Month, Day, Year)	1 2005 Regist	Signature JU.	P				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** February Charles Warren Bledsoe 27, 2005 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vantage House Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**∏**M 2□F Days Hours 577-48-6916 92 Yrs. Director 1912 Maryland Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits "naturel", or Items 23e or 28e-f show odical Examiner rust be notified at 1 Yes 2 No Directo Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 5400 Vantage_Point_Road, #411 **USA** Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Importent: If item 27 is marked other the any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: White Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Blind Rehabilitation Program Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Francis Bledsoe Harriet Edna Seal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hester Butterfield/Daughter 13541 Paternal Gift Drive Highland MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/28/05 Baltimore, MD Z. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road baltimore. 21. Signature of Funeral Service Licensee Edward A. Gregorchik 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12mg Immediate Cause (Final JAMEN 2 1 Jemin Dut **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 101 Ulson uchnot frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed bean 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has t page 2 No ertificate 1 Yes o the Hospitel or Attending Phys cian: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ĕ this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: A in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours at To the Funeral D 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 28, 2005 euro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AL Colinhas 101) 147 32. Regissar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

Funeral

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2 should be filed within 72 hours after and Mental Hygiene.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Cartificate of Dogth Reg. No.

	• Hegistrar	001	incate of Death	Re
	Decedent's Name (First, Middle, Last)			2. Date of Death
Physician /Medical	Kerry A. Bennett			FEBRUARY
Examiner	4a. Facility Name (If not institution, give street and n	um <i>ber)</i>	4b. City, Town, or Location of Death	
	PRINCE GEORGES HOSPITAL	CENTER	CHEVERLY	
Euporal	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth

2005 16, 4:14P. 4c. County of Death

PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days August 1,1975 Maryland

216-86-6523 Usual Residence of Decedent 10a. State 10b. County

10c. City, Town or Location Silver Spring

7. Age (In yrs. last birthday)

29

10d. Inside City Limits

10e. Street and Number 14 Long Green Ct.

10f. Zip Code 20906 10g. Citizen of What Country?

Completed by Funeral 11. Marital Status 1 Never Married 2 Married

MD

Director

Be

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12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indian Bfack, White, etc. Specify: Black

3 Widowed 4 Divorced 15. Decedent's Education

Year or Dates (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 10th

College (1-4or 5+)

NXM 2□ F

None

18. Mother's Name (First, Middle, Maiden Sumame)

17. Father's Name (First, Middle, Last) George Cobbs

Alfreda Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) Alfreda Bennett/Mother

Montgomery

14 Long Green Ct. Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

20a. Method of Disposition Burial 2 Cremation 3 Removal from State

Glenwood Cemetery

Feb. 24, 2005 Landover, MD

^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses

22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011

Date

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line.

Gunshot wounds (2) to torso and multiple sharp force myrines Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3. Time of Death

No Yes 2 □ No

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

4 Pregnant at time of death

3 Ectopic pregnancy

23d. Date of delivery Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes

24a. Was an autopsy performed 17 Yes

24b. Were autopsy findings available prior to completion of cause of 2 No

1X Yes 2 No 27. Manner of Death

4 Aomicide

25. Was case referred to medical

1 Naturaf 5 Pending investigation 2 Accident 6 Could not be 3 Suicide

1 🗌 Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Cebnuly 16,2005 3:00

Cther: 4 ☐ Nursing Home 28c. Injury at Work? 1 Yes 2 XV0

28d. Describe how injury occurred

26. Pface of Death (Check only one)

it assouthed 28f. Location (Street and Number or Rural Route Number,

5 ☐ Residence 6 ☐ Other (Specify)

29a, Certifier

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Hural House number of Hural House Number of Hural and manner stated

29c. License number

29b. Signature and title of certifier

lasha

OCME

29d. Date signed (Month, Day, Year) FEBRUARY 17,2005

+berg 30. Name and address of person who completed cause of death (fte 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

State Registrar 31. Date fifed (Month, Day, Year) 0

Green ber

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Mary Louise Bluteau February 15 2005 6:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care - Caton Harbor Baltimore Baltimore City Months Days Hours Min. 8. Date of Birth Oct. 1915 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 20 F 89 Virginia Director Yrs. Usual Residence of Decedent the Maryland 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits re!', or items 23a or 28a-f shov Examiner must be notified at Maryland N/A 1XYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 S. Ellwood Avenue 21224 U.S. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Completed by SpecifyWhite 3√2 Widowed 4 □ Divorced "neturel", 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) 12th Caterer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked James Ernest Padgett Molly Blanch Gwaltney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth tem 27 i Alice Bellamy / Social worker 10 North Calvert Suite 300 Baltimore, MD. 21201 if item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of importent: If any injury or once. ^¹ 4 □Donation 5 □ Other (Specify) Glen Haven Mem. Park 2/18/2005 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramerousk 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Range Frankus **Physician** C'Hron' disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Bloson CAnco TYPE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last anding physicien an use as the burial-tr Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BIROLAL Branker 2 🗆 DOTHANGED 1 Tyes 3 Probably 4 Unknown peen Call 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has breeter, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 2 No 1 Yes Other: Certification: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Box 68760. P.O. Division of Vital Records, After of in by the f filled in by within 24 hours a

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident investigation М 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Suicide 4 🗍 Homicide

29a. Certifier

(Check only one)

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fittle of certifier

29c. License number 29d. Date signed (Month, Day, Year) 24276

2224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huben

2.16.00

State Registrar

2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2009

the

			for State Registrar	State of	f Maryland		artment of F rtificate of		and Mental H	ygiene Reg. No	71115	06615
	Physicia		1. Decedent's Name (First, Middle	e, Last)					2. Date of I	Death Da	y Year	3. Time of Death
	/Medic		Mildred Eleanor						Febru		3, 2005	11:57 PM
	Examin	er	4a. Facility Name (If not institution	-	nber)		4b. City, Town, o		of Death		. County of Death	
			Maplewood Park 5. Social Security Number		7. Age (In yrs. la	act histoday)	Bethesda If Under 1 Year	If Under	24 Hrs 9 Date of F		Montgome	
	Funeral Director		579-14-2237	1 M 2 N F	87	Yrs.	Months Days	Hours	Min. 8. Date of E Month, I Sept. 2	Day, Year)	917 Washii	place (State or Foreign ntry) ngton, D.C.
7			Usual Residence of Decedent			-			вере: 2	-0, 1.	717 Wasiiii	igion, D.C.
Nar	thow H	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
e W	88-1 cillis	ecto	Maryland Montgo	mery	Beth	nesda	1			1		1 ☐ Yes 2 ☑ No
¥ith	a or	Funeral Director	10e. Street and Number	D1			10f. Zip Code				tizen of What Cou	
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(O	r lte		1 Never Married 2 Mar	Amed For	rces? 2X No				gin? (Specify Yes or No., Puerto Rican, etc.)	.0	Black, White,	
5-0036 72 hours after death with the Maryland	Pal, o	d by	3 ☒ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ates:		1 ☐ Yes 21K No	Specify:			Specify: Wh	nite
5-6-12-13-14-14-14-14-14-14-14-14-14-14-14-14-14-	natu	Completed		it's Education st grade completed)		16a. Deced (Give	tent's Usual Occup kind of work done DO NOT use retired	ation during mos	t of working	16b. K	ind of Business/In	dustry
2	then then	тр	Elementary/Secondary (0-12)	College (1	-4or 5+)	ine. i	Homemake				wn Home	
2 2	Hygin Sther ent, 1		17. Father's Name (First, Middle,	Last)			Homemake		or's Name (First, Midd			
Maryland 21215-0036	hental rked rked ic ev	To Be	George Frankli	n McIntur	Ef			Mild:	red Barnes			
ary	s ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural Route Num	ber, City o	or Town, State, Zip	Code)
Z , e	m 27		Patricia A. Cor	velli/ Si				e Aver		101,	Bethesda	, MD 20814
Baltimore,	Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Evantizer must be notified at once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from S	State 20b. Pl	ace of Dispo metery, cren Montoc	sition (Name of natory or other place mery_	(e)	Pebruary Pate	20c. La	ocation - City or To	own, State
tim	rtent:		'4 □Donation 5 □Other (S	_	Cre	natori	um, inc.		26, 2005		esda, Ma	
Ba	Depa Impo any ir		21. Signature of Funeral Service) H	M0Q689	Ве	thesda-Cl Bethesda	nevy (a. Mai	Chase, Inc cyland 208	755 14 – 35	nrey Fun 7 Wiscon 01	eral Home/ sin Avenue,
Ш				complications that conly one cause on e	aused the death ach line.	. Do not ent	er the mode of dyin	ig, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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60, be executed	physiclen and the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	ence of):						
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	attending lor use as	cian/Medica	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	come of pregnar irth 2 □ Fetal ant at time of de	death 3	Ectopic pregnancy	,			23d. Date of delive	ery Day Year
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Division of Vital Rec	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: Hospital: 1	inth 2 Fetal ant at time of de ant at time of de win sath but not resurred in patient 2 E of Injury h, Day Year) of Injury - At horng, etc. (Specify, best of my knowns of examination stated.	EP/Outpatien 28b. Time of Injury me, farm, str.) viedge, death ion and/or inv 23a) (Type,	t 3 DOA Other (specify) t 3 DOA Other (specify) 28c. Injury Wor M 1 Deet, factory, office 1 occurred at the time (sestigation, in my office) 29c. License D458	26. Place er: 4 \(\sum \) Nu y at K? Yes 2 \(\sum \) ine, date an pinion, dea	24a. We aut per 1 Yes of Death Check on rsing Home 5 Re 28d. Describe No 28f. Location City or T	I tobacco u]Yes 2 Is an opsy formed? 2 No one sidence a how injuriate own, State e cause(s) a, date and 29d. Date	Month Use contribute to the second of the s	Day Year the cause of death? pably 4 Unknown pasy findings available impletion of cause of 2 No Sisted No A Route Number, tated. the cause(s) Day, Year) 2005

DHMH 17 Rev 1/2001

				1 - State Registrar	ite of Mar		partment of ertificate of			iene ig. No: 005	06616
		Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	3. Time of Death
		/Medic		Geraldine L. Bird					Februar	y 24, 2005	12:00 PM
		Examin	er	4a. Facility Name (If not institution, give street a	and number)			or Location of Deat	h	4c. County of Deat	th
				Suburban Hospital 5. Social Security Number 6. Sex	7 000 /	(In yrs. last birthda	Bethes	da r If Under 24 Hrs.	0.0	Montgome	
		Funeral Director		151-14-4791	XI F	81 Yrs.	Months Day		(Month, Day,	Year) Co	thplace (State or Foreign
				Usual Residence of Decedent		01			December	28, 1923 New	Jersey
		rylan ihow	_	10a. State 10b. County	1	IOc. City, Town or	Location				10d. Inside City Limits
		Be-f s	Director	Maryland Montgomery		Potoma	2				1 ☐ Yes 2 🖾 No
		vith th	Dire	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co	ountry?
		s 23s	ırai	11801 Ambleside Drive	s Decedent Ev		20854			Jnited Star	
		ter de	Funeral	Ап	ned Forces? Yes 2 1 No		Was Decedent of If Yes, specify Cu	hispanic Origin? (S ban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
	936	urs af	by	If Y	es, Give ar or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: Wi	nite
	20	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	(leted)		cedent's Usual Occu			16b. Kind of Business/	
	21	ithin ben	npie		llege (1-4or 5+)	life	ive kind of work done a. DO NOT use retire	ed)	nking		
	121	led w lygier her th		Tabled New (Cas Add to Ass)	2	Pro	fessional			Self Emplo	oyed
	and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)				THE PARTY OF THE P	me (First, Middle, M	1,12	
	Z Z	hould d Me mark matic	ဥ	Florentine Schorn 19a. Informant's Name/Relationship (Type, Pri	nt1	10b M	ailing Addense (Chas		e Damming	city or Town, State, 2	
	Ma	and 2 should be filed within 72 hours after death with the Maryland balth and Mental Hygiene. n 27 is marked other then "natural", or Items 23a or 28e-f show her traumatic event, the Madical Examiner must be notified at		George B. Bird, Jr./	,						
		g 6 E 6		20a. Method of Disposition		20b. Place of Dis	position (Name of	1		Maryland	
	E G	Pages nent of I int: If Ite		1 Burial 2 □ Cremation 3 □ Remova '4 □ Donation 5 □ Other (Specify)	I from State	Ar	ematory or other plants of the	Mar	ch 8,	rlington,	Virginia
	Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Properat Service Meansee)	Nationa.	22. Name and Addi				neral Home/ venue
	m	20 5 5 8		Den	_ N	M01405	Rockville Rockville	, Inc. 30 . Marvlan	0 West Mc d 20850	ntgomery A	venue
				23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause						st,	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	5-mall	all	, ,	ancer			Onset and Death
		/Medical		resulting in death)	Due to (or as a c	consequence of):		7707			Time
	н	Examiner		Sequentially list conditions, b							
٤		ed sit	ine	if any, leading to immediate L	Due to (or as a c	consequence of):					
200pm		cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c	ue to (or as a c	consequence of);					
0	8760	be e sician buria	aiE		(,					
3	687	ficate g phys	edicai	d							
	Box	eath certific attending p I for use as	Physician/Me		es, outcome of					23d. Date of deli	verv
6	œ.	death e atte	icia	in the past 12 months?	Live birth 2 [Pregnant at time		3 □Ectopic pregnand 5 □ Other (specify) _	cy		Month	Day Year
10	0.	by the a	hys	9 D ONKHOWN	Unknown						
77	ŝ	The law requires that the death certifi tte has been signed by the attending oage 2 should be detached for use as	by F	Part II. Other significant conditions contributing	ng to death but r	not resulting in the	underlying cause g	iven in Part I.		acco use contribute to	
2	Record	w requir been s should	ted						1 46	s 2 □No 3 □ Pro	obabiy 4 Unknown
	ec	has b	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
2			Con						perform 1 ☐ Yes 2	ed? death?	2□ No
Bird	Vita	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	. /		10		th (Check only one		
	of	Phys this ral dii	- To	1 165 2 710	1 Impatient Date of Injury	2 ER/Outpat	ent 3 DOA	A Nursing H		nce 6 Other (Spec	ufy)
رقر	O	ding Ph h. After th funeral	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(ear) Injun	y Wo	ork? Yes 2 No	28d. Describe how	v injury occurred	
2	Division	or Attending after death. Director: After in by the fune	ertification:	3 Suicide 6 Could not be 28e	Place of Injury	- At home, farm,	street, factory, office		28f. Location (Str.	eet and Number or Ru	ral Route Number
B	ā		Cert	4 Homicide	building, etc. ((Specity)			City or Town,	State)	
eraldine		e Hospital 24 hours e Funerel letely filled	cai (29a. Certifier 1 Certifying Physician: (Check only 2 Medical Exeminer: Or	To the best of n	ny knowledge, de	ath occurred at the t	ime, date and place	, and due to the car	use(s) and manner as	stated.
Ď		판 든 판 등	ledical	one) an	d manner stated	d.			rred at the time, da	e and place, and due	to the cause(s)
		S IN TO S	Σ	29b. Signature and title of certifier	~ /	2	29c. Licen	se number	29	d. Date signed (Month	_
	•	00		Jon fin 4	1/3	Jun 1	10 02	2775		2/24/6	25
		U		30. Name and address of person who complete				#1200 ==	-1		
		Sta	te	Frederick Barr, M.D. 31. Date filed (Month, Day, Year)	32. # egistrar's	Signature		F1300, Ch	evy Chase	, Maryland	20815
	£	Registr		*** 0 1 2005	A	. H. 1	neede				

			1 - For State Registrar		ryland / De	epartment of l	Health and I	Mental Hyg	giene 005	066	17
			Decedent's Name (First, Middle, Last))				2. Date of Dea	ith	3. Time of	Death
	Physici			Myra K.	Byars			Februa	ry 23, 200!	6:21	P^{M}
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	th	
			Suburban Hospital	L		Ве	thesda		Montgo	nery	
	Funeral		Social Security Number 6. Se		(In yrs. last birtho	Months Days		(Month, Day	y, Year) 9. Bir	thplace (State or ountry)	r Foreign
	Director		220-36-3733]M 2₩F	89 Yr	S.		March 2,	1915 Wi	sconsin	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location	· · · · · · · · · · · · · · · · · · ·			10d. Inside Cit	ty Limits
	lanylé sho ed a	ō								1 🗆 Yes	-
	28a-	ect	Maryland Montgome	21 y		ensington		1	10g. Citizen of What Co	ountry?	
	with se or	Funeral Director	3333 University B	1vd. #403			895		United Sta		
	ns 23	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of If Yes, specify Cub				erican Indian,	
(0	rhar	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	,			to Rican, etc.)		e, etc.	
සු	eli, o	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: W	hite	
2-0	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "naturel", or Itams 23e or 28e-f show event, Ira Madical Examinat must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad		(0	ecedent's Usual Occu	during most of wor	rking	16b. Kind of Business	/Industry	
7	ithin	npf	Elementary/Secondary (0-12)	College (1-4or 5+	-)	fe. OO NOT use retire	ed)		70 1 1 1 1 1 1		
7	led w lygier her th		43 Cabada Nama (Cina Middle Lank)	4	Co	py Editor	10. Matheda Nes	ma /Cimt Middle	Publishin	g	
and	be fi	Be	17. Father's Name (First, Middle, Last) Edward Kellihe	3.m					Maiden Sumame)		
ž	J Mer narke	P_			105.1	Anilina Address (Ctron		garet Bur		7in Cadal	
Maryland 21215-0036	12 st h and 7 Is n traun		19a. Informant's Name/Relationship (T)						r, City or Town, State, . ix, Arizona		
Ģ.	1 and Health		Robert M. Byars/So 20a. Method of Disposition	11		risposition (Name of crematory or other pla		Date	20c. Location - City or		
2	ages int of t: If it		1 ☐ Burial 2 【 Cremation 3 ☐ I `4 ☐ Donation 5 ☐ Other (Specify)		Montgor	nerv	20/	uary 26,	Bethesda, N	Mary Land	1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Itams 23e or 28a-f show amy injury or other traumatic event, It a Madical Examinar must be notified at Once.		21. Signature of Funeral Service licens		Cremat	orium, Inc					
Ba	Depa Impo any i		Rutton	7.2	00198	Robert A.	Pumphrey	Funeral	Home/ Char a, MD 20814	ie, The.	. v y
	SECTION.		23a. Part1. Ent. the disease, or comp shock, or heart failure. List only o	lications that caused t	he death. Do no	t enter the mode of dy	ing, such as cardiac	or respiratory arr	rest,	Approximate	9
	Physician		Immediate Cause (Final		atory F					Onset and D 2 days	
	/Medical		disease or condition resulting in death)	a	consequence of)					2 days	
	Examiner			Conges		art Failur	e			2 days	
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of)	:					
	cutec	Examiner	that initiated events	c	L Fibril					2 days	
,092	te be executed ysician and le burial-transit		resulting in death) Last	Due to (or as a	consequence of)	:					
876		licai		d							
x 68	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE:	22a M. von autoama a	f ====================================						
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death	3 □Ectopic pregnance	су		23d. Date of de Month	,	/ear
0		ysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime or death	5 ☐ Other (specify) _					
<u>α</u>	de de		Part II. Other significant conditions co	ntributing to death bu	t not resulting in t	he underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	the cause of de	eath?
ds,	uires l signe	d by	Old Age					1 □ Y	'es 2 □ No 3 □ P	robably 4 ∏ U	Inknown
Records,	w requir been si should	Completed	General Debility					24a. Was a	an 24b. Were a	utopsy findings a	available
Re	The lav	d mc						autops	sy prior to med? death?	completion of ca	suse of
Vital		o C	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes :		2 🗌 No	
>		0	examiner?	Hospital:	t 2 ER/Outp	atient 3 DOA	100		ence 6 Other (Spe	cify)	
10	ding Phys h. After this funeral di	n:	27. Manner of Death	28a. Date of Injury (Month, Day		ne of 28c. Inju			ow injury occurred		
ion	Attending r death. ector: After by the fune	atio	1 XNatural 5 Pending 2 Accident investigation	(Worth, Day	, our,		Yes 2 No				
Division	er des er des recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injui	ry - At home, farm	, street, factory, office		28f. Location (St City or Town	Street and Number or R. n, State)	ural Route Numb	ber,
	tal or rs eft	Cer		1							
	To the Hospital or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the fi	edical	(Check only 2 Medical Exem	iner: On the basis of	examination and/				cause(s) and manner as date and place, and due)
	the hin 2, the f	Med	one)	and manner stat	ed.	29c Licen	se number	1 0	29d Date signed (Mont	h Day Year)	
	To the within To the comple	-	29b. Signature and title of certifier	my In	(·D		53601		Fobruary 2		
7	7			/ 4 A 4	u (h.) 5- :				February 2	+, 2005	
	10		30. Name and address of person who comes Mohsin Ijaz, M.D.				Doolers 1	10 Mary	land 20852		
	Sta	ete.			r's Signature		NUCKVII	Te, mary	1011G 20052		
	Regist		31. Date filed (Month, Pax Year) 1	ZUUD CUUL	Sin 10	Market					

1821 pm

BYARS, MYRA 2/23/05

Amend Item 5, per Info,G-841 3/9/05 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Yeer 40 **Physician** BARON Ani CELIA HELEN FEBRUARY 24, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL RANDALISTOWN NORTHWEST H Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) MAR. 23, 1926 5. Social Security Number 219-01-316 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Vrs 78 MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other than "naturel", or iteme 23a or 28e-f show treumatic event, it a Medical Examinating that the notified all 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1450 BEDFORD AVENUE #615 21208 USA 2 should be filed within 72 hours after death to and Mental Hygiene. Is marked other than "naturel", or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced WHITE 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) OF EDUCATION College (1-4or 5+) **SECRETARY** BALTIMORE COUNTY BOARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LOUIS **FEINSTEIN** ANNA SKLAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is m any injury or other treum <u>once.</u> 11 MARYHILL COURT - OWINGS MILLS, MD 21117 DAVID SPITZ / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHIZUK AMUNO ARLINGTON 2/27/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Edward KUUL 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis 1 da disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 NNo To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA the funeral dir this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 T Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU059736 Serveton 24 2005 ŋ

State

Registrar

MORTH WEST

FIUSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBURAH 31. Date filed (Month, Day, Year)

MAR 0 1 2005

MP

32. Registrar's Signature

Peggy Collins 05-01467 RPD

5-01 PD	467		- State Unpend Item	State of Mar	yland / De	partment of F	lealth and	Mental Hy	giene	0 E	06610
			Registrar 1. Decedent's Name (First, Middle, La		7,200 °C	ertificate of	Death	2. Date of De		UJ	3. Time of Death
	Physici		Peggy		Collins	3		Februa	Day	Year 2005	0126 A M
	/Medid Examin		4a. Facility Name (If not institution, giv			1	r Location of Dea			nty of Death	1 VI_ZO_A_
0			Bon Secours Hosp			Baltimo				I/A	
	Funeral Director		5. Social Security Number 6. S 215-60-7381	Sex 7. Age (1 1□M 2 X F 52	In yrs. last birthda Yrs.	Months Days	Hours Min		rth ay, Year) -1952	Coun	lace (State or Foreig try) imore, Mo
)			Usual Residence of Decedent					100	1002		
	arylan ehow	_	10a. State 10b. County	1	0c. City, Town or					1	0d. Inside City Limit: 1 XYes 2 □ No
	the M	ecto	Md. N/A		Balti	.more			10a Citizon	of What Coun	
	3a or	i Di	3009 Presburg	St		21216			USA	or writer Court	uy:
	death	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1	3. Was Decedent of H		Specify Yes or N		Race - Americ	
980	2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-1 show sumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		to rican, etc.)		Black, White, or Bla	
5-0	"natu	letec	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. De	cedent's Usual Occup ive kind of work done b. DO NOT use retired	nation during most of wo	orking	16b. Kind of	f Business/Ind	dustry
12	within ene. than	Completed by	Elementary/Secondary (0-12) 12	College (1-4or 5+) 4	1	ial Secu			Gove	rment	
9	filed Hygi other	0	17. Father's Name (First, Middle, Last					me (First, Middle	·		
/lar	uld be Venta Irked Itic ev	To B	Edward H	asty			Bern	nice	Hasty		
lan	2 sho and lis ma		19a, Informant's Name/Relationship (ailing Address (Street			-		
, 2	1 and 4ealth 3m 27 ther t		Necole Whitb 20a. Method of Disposition		20b. Place of Dis	7 Bright	on Stre	et,Bal		e, Md. on - City or To	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked eny injury or other treumatic esones.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro	(y)		position (Name of rematory or other place ional Pa	rk 3-3			el,Md	
Bai	permit Depar Impor any in		21. Signature of Funeral Service Lice	tep		ESTOPERT	others	Funera	1 Ser	.P.A.	
	Name of Street	-	23a. Part1. Enter the disease, or com	pplications that caused th						; Md. 2	Approximate
	Physician	Ш	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Methadon Due to (or as a c		Callon				-	
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	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a c	consequence of):						
•	xecut and al-trar	хап	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):						
,092	ate be executed hysician and the burial-transit	cal		d							
Вох 68	ath certific titending p or use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	у		1	Date of delive Month	ry Day Year
S.	ires that the de signed by the a I be detached f	Phys	9 X Unknown					ag - Did			
rds,	w requires the been signed should be d		Narcotic Use	contributing to death but i	not resulting in the	underlying cause giv	ven in Part I.		Yes 2□No		e cause of death? ably 4 knknowi
Division of Vital Records,	The law rate that he page 2 shi	Completed by						24a. Was auto perfe 1X Yes		prior to cor death?	osy findings available pletion of cause of 2 No
Vita	certify rector	Be	25. Was case referred to medical examiner?	Hospital:	V	Oth		ath (Check only		,	
of	Phys r this sral di	: To	1 X Yes 2 No 27. Manner of Death	1 Inpatient	OOD Time		ner: 4 ☐ Nursing I ry at	Home 5 ☐ Res 28d. Describe			unk
ion	nding ath. r; Afte e fune	atlor	1 ☐ Natural 5 ☐ Pending investigation	/ / /))	Four In T	PM 1□	rk? Yes 2 X No				
Divis	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, (Specify) residen	street, factory, office		28f. Location (City or To Baltimo	Street and Nu wn, State 27 ore, M		Route Number, Lem Ave.
	e Hospit 24 hours e Funera letely fille	edical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exe	hysicien: To the best of a miner: On the basis of ea and manner state	camination and/or	ath occurred at the tir investigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
	To th To th compl	3	29b. Signature and title of certifier	Allann	nd	29c. Licens			^{29d. Date sig} Februar		
1	JK PO	منا	30. Name and address of person who	completed cause of dea	th (Item 23a) (Typ		nn Stree	t Balt	imore,	Maryla	and 21201
\$°	Sta		31. Date filed (Month, Day, Year)	32. Registrar's							
	Registr	3 30	MAR 0 1 200	Bloom	H. A.	Add A					
DH	MH 17 Rev 1/2	001			ORIGII	NAL					

		Registrar 1. Decedent's Name (First, Middle,	Last)		ertificate of D		2. Date of Death	2 _{ay} 26-20	06621
Physici /Medic		Angela	R.	Con	ırad		Februar	25 25	3005 11:40
Examir		4a. Facility Name (If not institution,			4b. City, Town, or Lo	ocation of Death		4c. County o	
	Ш	1475 Mordor Lane			Severn				Arundel
Funeral		,	S. Sex 7. Ag	ge (In yrs. last birthday Yrs.		f Under 24 Hrs. Hours Min.	(Month, Day, 1	Year)	 Birthplace (State or For Country)
Director		219-15-0188 Usual Residence of Decedent		32			Dec. 28,	1972	Maryland
MO TH		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Lin
B-f s	io	Maryland Anne	Arundel	Glen Bur	nie				1 ☐ Yes 24€
or 28	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of Wh	nat Country?
238		304 Julie Dale	Drive		21061		U	nited S	tates
or items 23a or 28a-f show its itsermust be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
8	by Fi	1 X Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give	No	_	Specify:		Specify:	White
"natural", Jical Exp	ed b	15. Decedent's	Year or Dates:	16a Dec	edent's Lleual Occupation	20			
dedical	Completed	(Specify only highest	grade completed)	(Giv	edent's Usual Occupation e kind of work done dur DO NOT use retired)	ing most of work	ring	6b. Kind of Busi	mess/maustry
ylene.	E O	Elementary/Secondary (0-12) 12	College (1-4or	0+)	Service Wo			Food	Service
ital Hygiene. d othar than "natu evant, it a Medical	Be C	17. Father's Name (First, Middle, La	ast)		18	8. Mother's Nam	e (First, Middle, Ma		
	70	George W. Conra	Ē		1	Mary E.	Spiegel		
a a a		19a. Informant's Name/Relationshi			ling Address (Street and				
Health lem 27 thar tre		George W. Conrac	d - Father		Julie Dale	Drive	Glen Bur	nie, Ma	ryland 210
If iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	March	Date 20	c. Location - C	ity or Town, State
tent: jury		4 □ Donation 5 □ Other (Spe	icify)	Metro Cr		2005		atonsvi	lle, Maryla
Department of Property of Importent: If ite any injury or of once.		21. Signative of Funer II Service Li	censee	ķ	P. Name and Address irkley-Rudo 21 Crain Hi	of Facility	eral Home	P.A.	21061 e, Maryland
J = 85 OF		23a. Part1. Enter the disease, or c							e, Maryland
physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):					
On 60	ledical	IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome					23d. Date (of delivery
y the ached	Physiclan/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4☐ Pregnant at 9☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	n Day Year
s been signed be should be detailed	by	Part II. Other significant condition	s contributing to death b	ut not resulting in the I	underlying cause given i	n Part I.	23e. Did tobac	/	ute to the cause of death ☐ Probably 4 ☐Unkn
ate has page 2	Completed						24a. Was an autopsy Performe	d? 24b. We prio dea	re autopsy findings avail or to completion of cause ath? Yes 2 \(\text{No} \)
is certific director,	Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital:		Othor		(Check only one)		
After th funeral	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	2-70-03	ry 28h Time (of 28c. Injury at Work?		me 5 🗌 Residenc 28d. Describe how		
willing 24 noors are reading to the Funaral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no determin	House	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		Severn, N	1475 (D	or Rural Route Number, Mordor Land
Funa Bely fil	edical	(Uneck only 21 X Medical E)	Physician: To the best aminer: On the basis of	examination and/or in	th occurred at the time, avestigation, in my opinion	date and place, a	and due to the caus	se(s) and mann	er as stated.
the	Med	one)	and manner sta	ited.					
CO 70	en .	29b. Signature and title of certifier	meller	10 100	29c. License nu OCME	190mi			Month, Day, Year) 27, 2005
	,	Name and address of person wh							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** Coffelt alvin N 1:47 17 M 25 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** USA MI North Arundel Huspital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☑ M 2 ☐ F 64+ Yrs. 220362434 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow item 27 ie marked other than "natural", or itema 23a or 28a-f ehov other traumatic event, the Mudical Examinal must be notified at Mi ANNE Hrundel 1 ☐ Yes 2 No by Funeral Director HEN SURNIC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue Sw 2NI) 21061 USA 4t 07 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 158-162 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Mechanical Engineer Research & Development permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other
any injury or other traums**

900ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norman Coffelt Maude M. Marston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth I. Coffelt/ Wife 407 Second Ave., S.W., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State March 1, 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. * 4 □ Donation (5 □ Other (Specify) Catonsville, Maryland 21. Signature of Fune. I Service Licensee Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., SE., Glen Burnie, MD 21061 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** in. wes /Medical Due to (or as a consequence of) **Examiner** circlistisculo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, ector, page 2 should be inheres mellitus 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1° Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00033296 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) 7711 adyet Guarterfield RD GlenBurne MD 21061

State Registrar 31. Date filed (Month, Day, Xear)

DHMH 17 Rev 1/2001

32. Segistrar's Signature

_		1 - State Registrar AMENI) ITE 1. Decedent's Name (First, Middle,		G841 99	digrase su	Death	2. Date of Dea	Reg. No.	05	0662
hysici		ROBERT COLLIN	,				Month	Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Dea	FFS TUME		2005 inty of Death	1130
- Admini		JOHNS MPKINS B	AYVIEW		BALTIM				MINON	5
ineral			. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 H		h Vaar		place (State or For
ector		218-84-4230	1⊊M 2□F 34	Yrs.	World Days	Hours Mil	Nov. 2			vland
* -		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ecation					10d. Inside City Lir
28a-f show	jo	Marana		,,						1 ☐ Yes 25
28a	Director	Maryland I 10e. Street and Number	Baltimore		10f. Zip Code	M:	iddle Riv	er 10g. Citizen	of What Cour	
23a or ust be		405 Grovethorn	Road			21220				•
item 27 is marked other than "natural, or itams 23a or 28a-f shoy other traumatic event, the Medical Exama with ust be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of		(Specify Yes or No- erto Rican, etc.)	14. F	ed Sta	can Indian,
or Ita	F	1 ☐ Never Married 2 ☑ Married			iYes, specify Cub 1 ☐ Yes 2 ☑ No		erto Hican, etc.)		Black, White,	etc.
natural,	d by	3 Widowed 4 Divorced	Year or Dates: 19	93-97	TE THS ZIZINO	Specify:		Spe		White
nati	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of	Business/In	dustry
r Is marked other than " raumatic event, the Med	du	Elementary/Secondary (0-12)	College (1-4or 5+)			id)				
ther int, it		12 Years 17. Father's Name (First, Middle, La	st)	Li	neman	19. Mothor's No	ame (First, Middle.	Amtra		
e e ve) Be		ollins, Jr.						rame)	
mati	၉	19a. Informant's Name/Relationship		19h Mailin	an Address (Street		nel Tawney Rural Route Numbe		- C4-4- 7'-	0.41
Z/ Is		Mrs. Michele C			Grovetho		Middle 1			21220
othe		20a. Method of Disposition			sition (Name of natory or other pla			20c. Locatio		
, o		12 Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe								
in in in	- 1	21. Signature of Funeral Service Lic		22	1 Mem. G	ss of Facility				er, MD
Important: If item 27 is any injury or other traconce.		Stephan	· · Man	D	uda-Ruck	Funeral	Home of Dundalk,	Dunda.	lk, In	1222
		23a. Part1. Enter the disease, or co	mplications that caused the de	eath. Do no ente	er the mode of dyi	ng, such as cardia	ac or respiratory arr	est.	and 2	Approximate
ician		shock, or heart failure. List on Immediate Cause (Final		110 011						Interval Between Onset and Death
dical		disease or condition resulting in death)	a. SEVELF R Due to (or as a cons.						4	4 DAYS
niner			b. SEVERLE EI		NULLAL ZI	V			L	PAYS
.=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consi			-		_		1 121113
trans	Examiner	that initiated events	C				EXAMIN	EM		
burial-transit	<u>~</u>	resulting in death) Last	Due to (or as a cons	equence of):		-0.	EN MEDICAL			
È ë	dlcal	•	d			TION APPROVED	/			
for use as I	Me.	IF FEMALE:	00 1/		CERTIF	CATION APPRO	EN MEDICAL EXAMIN			
for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1☐Live birth 2☐Fe	etel death 3 [Ectopic pregnancy	, 04		=00. 2	ate of delive	ry Day Year
peq:	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)				MOST (LT)	Day real
		Part II. Other significant conditions	contributing to death but not re	asulting in the un	idestvina cauca an	on in Part I	22a Did tob	22222 1122 22	maniferran an ak	e cause of death?
ed b	β	NOWE	3	,	adding ing daddo giv	on in rait i.	1 □ Ye			ably 4 DUnkno
should	ete						-			ably + Donkho
page 2	Completed by						24a. Was a autops perforn	y	. Were autor prior to con	osy findings availal appletion of cause of
		05 14/						No	1 Yes	2 No
3 9	o Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only on			
- I	-	1 Yes 2 No 27. Manner of Death	1 Minpatient 2	☐ ER/Outpatient 28b. Time of	The second secon	4 🗀 Nursing i	Home 5 Reside)
funer	Certification:	1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injur Wor	Yes 2 □ No	28d. Describe ho	IN AIGH	VOLTANI	FLINE
y the	Ica	3 ☐ Suicide 6 ☐ Could not	LEDENHET IT TOOL	D600		162 5 100	296 Lanation (Ct	unnt d Moor		
l in by 1	erti	4 Homicide determine	building, etc. (Spec	cify)	ец, тастогу, оптсе		28f. Location (Str City or Town	, State) 64	BROA	D ST
		29a. Certifier 1 Certifying F	Physician: To the best of my kn	nowledge, death	occurred at the tin	ne, date and place	TANK TOLD	AVE.	SPUIME	LE MD
letel	edical	(Check only 2 Medical Extended one)	Iminer: On the basis of examination and manner stated.	nation and/or inve	estigation, in my o	pinion, death occi	urred at the time, da	ite and place	, and due to	the cause(s)
		29b. Signature and title of certifier			29c. Licens	a number	29	d. Date sign	ed (Month, E	Day, Year)
dwo) Omm	MD		- T4087		P	Num	v a 1 2	nnc -
complet			1 11/							
dwoo :	0	30. Name and indress of person who	completed cause of death (Ite	em 23a) (Type P			r	FBRUML	1 6116	2003
dwo		30. Name and ordress of person who	completed cause of death (Ite				P	E BILVIAN	1 616	2002

			1 - For State Registrar	State	of Marylar		artment of I		and Ment		ene 005	5 06	623
			Decedent's Name (First, Midd	lle, Last)					2. D	ate of Death	. 140.	3. Tir	me of Death
	Physic			Ма	ry Rose	e Czyz				lonth	Day Ye 7 23, 20	ar	
	/Medi Examir		4a. Fecility Name (If not institution	on, give street and n	umber)		4b. City, Town,	or Location o		pruary	4c. County of D		0:50A ^M
1	Lxamii	iei							n Deam				
-	Formand		31 Wiltshire R	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	SSEX If Under 2	24 Hrs 0 D	ate of Birth		more C	
	Funeral Director			1 M 2 St		Yrs.	Months Days		Min. (N	fonth, Day, Y	ear)	Country)	tate or Foreign
			216-18-4683 Usual Residence of Decedent		82				Ar	oril 28	3,1922	Maryla	nd
	rland ow		10a. State 10b. County	1	10c. Cit	y, Town or Lo	cation					10d. Insi	de City Limits
	Many 1 sh	ģ	N	D = 1 to 1									Yes 24020No
	the 288	Director	Maryland 10e. Street and Number	Baltimor	e		10f. Zip Code		Essex	100	. Citizen of What	0	
	with with		31 Wiltshire	Dond			101. Z.p 0000		21221	109		•	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28a-1 show event, the Medical Exam are nurst be multiled at	Funeral	11. Marital Status		cedent Ever in U	6 12 1	Mas Dogodost of I	lianania Oria	21221	to a subtra	United		
	ter d	ä	1 Never Married 2 Mar	Armed F	orces? 2 1 No	.3.	Vas Decedent of I f Yes, specify Cub	an, Mexican	, Puerto Rican	es or No- , etc.)	Black, W	merican India 'hite, etc.	n,
36	rs af	by	3 ☑ Widowed 4 □ Divorced	If Vas G	ive		☐ Yes 2⊠ No	Specify:			Specify:	1	
ö	hou	ed		nt's Education		16a Decer	lent's Usual Occur	nation		140	1 10 1 10	Whi	te
15	in 72 "n" r	Completed	(Specify only highe	st grade completed		(Give	kind of work done OO NOT use retire	during most	of working	16	b. Kind of Busine	ss/Industry	
72	within ene. then "	Ē	Elementary/Secondary (0-12)	College	(1-4or 5+)		achine O				Ecckar	, Pood	-
9	e filed within al Hygiene. i other then ' vent, the Me		17. Father's Name (First, Middle.	Last)		11	achine o			Middle Me	iden Sumame)	Foods	>
an	ould be Mental arked o	Be.	Louis Merlet	-+0				TO. MOUTO	Antoin		,		
$\overline{\geq}$	should be nd Mental marked (imatic ev	2	19a. Informant's Name/Relations			105 14-35-							
Maryland 21215-0036	d 2 s th an T is		Mrs. Elizabeth		ster		g Address <i>(Street</i> 2 Garden						21206
	1 an Heali em 2 ther		20a. Method of Disposition	T ROCK/ DI			sition (Name of	V 1 1 1 C	Date	-		_	
و	ages or o		15⊡Burial 2 ☐ Cremation		State	emetery, cren	atory or other pla				c. Location - City		
Ę	t. Partmer		□ Donation 5 □ Other (S		Ga		of Faith				Rossvill		ryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic es <u>pace</u> .		21. Sign ture of Funeral Service	ticensee	2. Q		Name and Addre da-Ruck 922 Wise					nc. 21222	
			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that	caused the death							Approx	
	Physician		Immediate Cause (Final	only one cause on		Irate.						Onset a	Between and Death
	/Medical		disease or condition resulting in death)	a	(or as a consequ		9 10	ulum	٤				
	Examiner			Due to	(or as a corrisequ	CIP V	2						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):							
	ansit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events	S									
~	exec n and ial-tra	Examiner	resulting in death) Last	c. Due to	(or as a consequ	uence of):							
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.89	ficati g phy is the	a		U									
Вох	eath certif attending for use a	M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						22d Date of a	la liva and	
m	atte	Cla	in the past 12 months?		birth 2 Fetal		Ectopic pregnancy Other (specify)	1			23d. Date of d Month	Day	Year
P.O.	that the death cerred by the attendindetached for use	Physician/M	9 Unknown	9□ Unkn			other (specify)						
	that led b		Part II. Other significant condition	ons contributing to d	eath but not resu	Ilting in the un	derlying cause giv	en in Part I.	23	Be. Did tobaco	co use contribute	to the cause	of death?
Records,	uires tha signed I id be det	d by								1 🗀 Yes	_	Probably 4	
õ	w requir been s should	Completed							_	-			
e E	has ge 2 :	mp							24	a. Was an autopsy	24b. Were prior to	autopsy findir completion	igs available of cause of
 	icien: The certificate ha								10	performed Yes 222			
Vital	sicien: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:					of Death (Chec				
ō	Phys this al dii	To	1 Yes 2 1 No	1 1 1	_	ER/Outpatient			sing Home 🐒			ecify)	
Division of	ding F h. After funera	lon	27. Manner of Death 1	9	th, Day Year)	28b. Time of Injury	28c. Injun World	k?		scribe how in	njury occurred		
S	Attendil er death. ector: A by the fu	cat	2 Accident investig	not he				Yes 2 □ N	0				
\geq	or All	Certification:	4 Homicide determ	ined 288. Place	of Injury - At hor ing, etc. (Specify	me, farm, stre)	et, factory, office		28f. Loc Cit	cation (Street y or Town, St	and Number or late)	Rural Route N	lumber,
	urs a		*										1
	Hos 24 ho Fune tely fi	lica	29a. Certifier Certifyin	g Physician: To the Examiner: On the b	asis of examinat	vledge, death ion and/or inve	occurred at the timestigation, in my or	ne, date and pinion, death	place, and due	to the cause	e(s) and manner a	as stated.	se(s)
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical		and man	ner stated.								
	F 3 5 0	-	29b. Signature and title of certifier	n.			29c. License	number	-	29d. I	Date signed (Moi	nth, Day, Yea	")
	1			den M	MIN	N	11/	1378		3	1241	03	
	N/		30. Name and address of person	who completed caus	se of death (Item	23а) (Туре, Р	rint)	0 1	B-1	1 44	0 0		
			sheldon Milne	1, 1n. 0.	4110	Mila	Pl mint) delphia	KU	1101	te,M.	0 21	23)	
	Stat		31. Date filed (Month, Day, Year)	R 0 1 200	egistrar's gnat	ure A	hack	14					
	Registra	11	MIM	11 O T 500	- MARIE		1 Same						

ULOTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND ITEM #10e&19b PER FH 684tifics/192705eath Reg. No. 2. Date of Death Day **Physician** 26+4 Madalene D. Currens FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT BALTIMORE AGNES HEAZTH CARE If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) 10/18/1941 **Funeral** Days 1 M 2 F 220-38-8448 Director 63 Yrs Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Director MD Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ŏ 6028 Black FRIARS rcle itams 23a 21228 U.S.A. death (Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after c and Mental Hygiene. is marked other than "natural", or Itan Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden, Sumame) Pages 1 and 2 should be nent of Health and Mental Norman Dallas Madalene Wirts 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stranged Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is: any injury or other traun Melvin Wright - Friend 6028 Black Fires Circle Catonsville, MD 21228 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Park 3/2/2005 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Upper **Physician** gastrointest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-t Due to (or as a consequence of) attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 212 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital or Attending Physician: 1 Yes 2 0 No Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or
To the Funeral Direc 4 - Homicide 29a. Certifier 1 (Tycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number DOCTOR 18622 MEDICAL 10ml

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

February 26th 2005

2005

Birthplace (State or Foreign Country)

10d Inside City Limits

1 Yes 2 No

days

Years

Year

Day

2 No

Yes

MD

White

30. Name and address person who completed cause of death (Item 23a) (Type, Print) CATON YNIECKI 300

AVENUE

Registrar

31. Date filed (Month, Day, Year) MAR 01 2005 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Richard Michael Carroll, Sr. February 21 2005 11:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 903 Circle Drive Arbutus Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 2 Pay, 1942 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 M 2 □ F 62 218 42 5654 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 Circle Drive 21227 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Draftsman RFF - Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Carroll, Sr. Margaret Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Carroll, Jr. / son 3127 Cornwall Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Glen Haven Mem Park 2/25/2005 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Keome 4001 Ritchie Highway Baltimore, Maryland 21225 noncocy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORONAD disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner SOK resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Y021 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only ope) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760, the P.O. Division of Vital Records, After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the

Funeral

Director

Items 23a or 28a-f show

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natural

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the Medical Examiner must be notified at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

if Health and Mental Hygie item 27 is marked other

permit. Pages Department of I Important: If it any injury or o

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 01 2005

mellowetathe sch

30. Name and address of person who is impleted cause of death (Item 23a) (Type, Print

29b. Signature and title of certifier



FEDENCHOICE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	f Maryland /	•	artment of H tificate of L		d Menta		ne ()5	06627
			Decedent's Name (First, Middle,	Last)					2. Date Mon	of Death	Day	Year	3. Time of Death
	Physicia		Ronald John	Francis	s Chesloo	ck				ruary	22, 2	2005	Unknown M
	/Medic Examin		4a. Fecility Name (If not institution,	give street and nur	nber)		4b. City, Town, or	Location of D	eath		4c. County	of Death	
	LXamili	C1	722 Sequoia D	rive			Edgewo	od			H	Harfo	
	Funeral			. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date	of Birth	ear)	9. Birth	place (State or Foreign
	Director		219-38-0711	XXM 2□F	63	Yrs.	WOTHING Day's	110013	Feb	. 26,	1941	Penn	sýlvania
	g .		Usual Residence of Decedent		don Oity To								10d. Inside City Limits
	thow	_	10a. State 10b. County		10c. City, To	WIT OF LO	cation						1 □ Yes 2 No
	e Ma	cto	Maryland Harfo	rd	Edge						00001	111	
	or 20	Director	10e. Street and Number				10f. Zip Code				. Citizen of \	What Cou	ntry?
	23e	la	722 Sequoia Driv				21040		2/2 // 1/		USA	A	can Indian,
	tema serie	Funeral	11. Marital Status	Armed Fo		13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin n, Mexican, P	? (Specify Yes Puerto Rican, e	s or No-		ck, White,	
36	72 hours after death with the Maryland natural; or Itema 23e or 28e-f show diest Examinational te notilind a	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Voc Gi	²⊔№ ates: Vietnan		1 ☐ Yes 2 📉 No	Specify:			Specify	y: TAT	hite
21215-0036	hour tural		15. Decedent's				dent's Usual Occup	ation		16	ib. Kind of B		
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Maryland	buid be Mental arked c	To Be	John (nmn)	Ches	lock			Flore	nce	(u/k)	ç	Sadow	ski
<u></u>	shoul mari	-	19a. Informant's Name/Relationshi			9b. Mailir	ng Address (Street			1			
S	lith ar 27 la 27 la		Harold Dwaine Q	uante - 9	Step-son '	722 \$	Secuoia D	rive,	Ed ewo	od, M	arylar	nd 21	040
ē,	Hea Hea Herm Herm other		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place		Date	20	c. Location -	- City or T	own, State
OL	ages ant of st: If I		1 Burial 2 Cremation : 4 Donation 5 Other (Sp.		State		Service (-28-05	т	hwen	Mar	yland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Ia marked any injury or other traumatic es once.		21. Specture of Funeral Service L		\wedge	22	2. Name and Addre	ss of Facility	McComa				
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			23a. Part1. Enter the disease, or o shock, or hear failure. List of	complications that	aused the death. D								Approximate Interval Between
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oʻ	exection and and rial-tr	Exa	resulting in death) Last		(or as a consequence	e of):							
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and trial director, page 2 should be detached for use as the burial-transit	dicai		d									
9	tifica ng ph as th												
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy	ath 3[∃Ectopic pregnancy	,				ate of deliver	very Day Year
	ne deal the att hed fo	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	nant at time of death	5 [Other (specify)				1	orter)	Duy
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the	Med	one) 29b. Signature and title of certifier	and mai	nner stated.		29c. Licens	se number		29	d. Date signe	ed (Month	, Day, Year)
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	St Regist	ate rar	MAR	0 T 5002.	Charles and Carlotte and Carlotte		* #						

	•	For State Ragistrar	or Maryland	/ Department of Certificate of		Reg. h	0000	06628
		Decedent's Name (First, Middle, Last)			2	. Date of Death	ay Year	3. Time of Death
Physicia /Medic		Albert Findlay Car	r			bruary 2	6 2005	820 PM
Examine		4a. Facility Name (If not institution, give street and Franklin Square Ho	spital		on, or Location of Death	4	Balti	more
uneral rector		5. Social Security Number 6. Sex 1X M 2	7. Age (In yrs. last		ear If Under 24 Hrs. 8 ys Hours Min.	Date of Birth (Month, Day, Yea eb. 15,	9. Birth Cou	place (State or Foreign intry)
W #1		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
a-f she iffied a	ţo	MD Baltimore	Park	kville				1 Yes 2 No
or 28	Director	10e. Street and Number		10f. Zip Coo	е	10g. C	itizen of What Cou	intry?
HELE		8810 Walther Blvd.		212			nited Sta	
Examinatio	by Funeral	1X Never Married 2 Married 1 Never Married 2 If Yes	Decedent Ever in U.S. d Forces? 'es 2 □ No WW] s, Give or Dates:	If Yes, specify (of Hispanic Origin? (Specif Luban, Mexican, Puerto Ric No <i>Specify:</i>	ey Yes or No- can, etc.)	Black, White	
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ut, #		17. Father's Name (First, Middle, Last)	51	Super Visor	18. Mother's Name (#			
tic ev	To Be	Thomas Carr			Elizabet	h Findl	ay	
item 2.7 is marked other than natural, or tems 2.5s or 2ss-1 show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print, Bill Harvey/friend)	-	eetand Number or Rural F Drive Severn			
If item 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f	rom State cem	se of Disposition (Name of netery, crematory or other	place)		Location - City or 1	
Important: If I any Injury or o QDCB.		` 4 ☐Donation 5 ☐ Other (Specify)	Rural	Cemetery	03/07/		w Bedford	
any In		21. Sign were of Funeral Service Licenses St.	ephen Coste		dress of Facility Ruck rk Road, Tow		runeral 1 21204	Home, Inc.
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iner	er	Sequentially list conditions, b.	JUGMOUS C	ellcarcino	ma of the	e face		1 year
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DHMH 17 Rev 1/2001

			For Stata Registrar	State of M	aryland	-	artment of rtificate of		and M		- L U	105	066	29
			Decedent's Name (First, Middle, La.	st)						2. Date of Deat			3. Time of i	Death
	Physicia /Medic		DeSales		Cole					February	/ 23,	2005	9:42	P^{M}
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location o	of Death		4c. Cou	nty of Death		
			Manor Care Dulane				Towson	- 1 - 2 - 1			Balt	timore		
	Funeral Director		5. Social Security Number 6. S 220–16–8960	ex M 2□ F 7. Ag	je (In yrs. la	st birthday) 80 Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, January 2	, 1925	9. Birthr Cour Mary	lace (State or try) and	Foreign
	pu 🌬		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation						Od Jasida Oik	Limita
	Aaryla r shor	ō	MD Charles	el Alto										
	the N	rect	10e. Street and Number			- 71100	10f. Zip Code			10	g. Citizen	of What Cour		
	3e or	Ö	8150 Bel Alton Newto	wn Road			2061	1				S.A.	-,-	
	deatt	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13. \	Was Decedent of f Yes, specify Cul	Hispanic Original	gin? (Spec	cify Yes or No-		Race - Americ Black, White,		
36	rs after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:			1□Yes 2XDNo		,	, , , , ,		city: Bla		
8	2 hou		15. Decedent's Ed	lucation		16a. Deced	dent's Usual Occu	pation		1	6b. Kind of	f Business/Inc	dustry	
21215-0036	thin 7 e. en "n	Completed	(Specify only highest gra	College (1-4or:	5+)		kind of work done DO NOT use retir		t of workin					
2	lad wi		17. Saltada Narra (San Middle 1 an)	n/a		Cc	oncrete Fi						Commerc	ial
Maryland	t ba fi	Be c	17. Father's Name (First, Middle, Last) Daniel Co	le .					nnie	(First, Middle, M	Gross	iame)		
Z	should nd Me mark imatic	²	19a. Informant's Name/Relationship			19b. Mailin	g Address (Stree			Route Number,		vn, State, Zip	Code)	
	alth a		Mary Cole/ wife			P.O.	Box 162, 1	Bel Alto	on, Ma	ryland :	20611		,	
ore,	of He of He fitam		20a. Method of Disposition 1 Burial 2 Cremation 3	Demoval from State	COL	ice of Dispo	sition (Name of natory or other pla	ace)	Da	ate 2		n - City or To	wn, State	
altimore,	Pag mant tant: I		`4 ☐ Donation 5 ☐ Other (Specify	<i>'</i>)	Sac		irt Cemetei	,	3/3/05			ata, MD		
Ball	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic avant, Itie Medical Examinar must be notified at once.		21. Signature of Funeral Service Licen	‱ William (G. Dau		. Name and Addr .050 York 1				Funera 7	l Home,	Inc.	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused	d the death.	Do not ente	er the mode of dy	ing, such as	cardiac or	respiratory arre	st,		Approximate Interval Betw	veen
	Physician :		Immediate Cause (Final disease or condition		ECTI	ous	Coz	-ITIS					Onset and De	
	/Medical Examiner	resulting in death) Due to (or as a consequence of):												
		e.	equentially list conditions, any, leading to immediate Due to (or as a consequence of):											
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (visease or injury that initiated events	,		,								
oʻ	cata be axecuted physician and the burial-transit	Еха	resulting in death) Last	Due to (or as	a conseque	ence of):								
8760,	ata be hysici the bu	dlcal		. d.										
9	= 20	a)	IF FEMALE:	220 If you outcome	of prognan	Ou 4								
Вох	The law requires that the death cartificate has been signad by the attending page 2 should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal c	death 3	Ectopic pregnand Other (specify)	у				Date of delive Month		ear
o.	that the de lad by the a detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown			Callor (apoony)							
<u>a</u>	res that ignad b	y PI	Part II. Other significant conditions of			-	nderlying cause g	ven in Part I.		23e. Did toba	acco use co	ontribute to th	e cause of de	ath?
rds	w require been sig should b	edt	ALZHEIMER'S	DEMEN	JTIA					1 ☐ Yes	2 □ No	3 Prob	ably 4 Don	iknown
Vital Records,	law re as be	plet								24a. Was an autopsy	241	b. Were autop	osy findings av	vailable use of
<u> </u>	sician: The law certificate has b lirector, page 2 s	Con								perform	ed? D No	death? 1 🗌 Yes	,	
Vita	ysician: iis certifica director, I	Be	25. Was case referred to medical examiner?	Hospital:			0:			(Check only one				
o	Phys this ral dir	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		R/Outpatien 28b. Time of	t 3 DOA 28c. Inju	nvat	rsing Hom	e 5 🗆 Resider	nce 6 C	Other (Specify)	
O	iding Phy th. : After this funeral o	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	Wo	ork?]Yes 2.⊟1		od. D0301100 1101	v injury occ	31100		
Division	Attar er daa ector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At hom	ne, farm, stre	eet, factory, office		28	8f. Location (Stre City or Town,		mber or Rura	Route Numbe	ΘΓ,
ā	tal or rs afte al Dir	Cert	4 Hottlede	Duilding, et	c. (Spacity)				W	City of Town,	Siale)			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best liner: On the basis o and manner st	f examination	ledge, death on and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, ar th occurre	nd due to the cau d at the time, dat	use(s) and i	manner as sta e, and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier					se number				ned (Month, L		
	W		Ma, M.D.				D009	59107	+	-1BERTY	2-2	5-25	05	
	107		30. Name and address of person who a KALU UMA M. D 31. Date filed (Month, Day, Year) MAR 0 1 2	completed cause of o	leath (Item 2	23a) (Type, I	Print)	260 RM	N L	-1BERTY RG N	nerc	MTS A	NEWNS	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	re	7,700,1	12714	11110	1, 2	ررت	-1412		
	Registr		MAR 0 1 2	005 Rens	W. J. M	y. A	rede							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** February 25, 2005 R. 8:10 p Margaret Coburn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll County General Hospital Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 14, 1936 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 🔽 F 215-34-5671 Director Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Carroll Hampstead 1 ☐ Yes 2 X No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1307 Country Park Drive 21074 Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Sales Photography Stores 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen J. Rabel Margaret Μ. Murray ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Jeff Coburn-son 8302 Dalesford Road, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DABurial 2 Cremation 3 Removal from State 0 Department of Important: If any injury or once. Dulaney Valley Mem'l Gardens 3/2/05 Timonium, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau Milh 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician 14 DA45 disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Physiclan/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by pe 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 20 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2005 00059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLE RD WESTMINSTER 6-OURISHANKAR NAGANNA 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State MAR 01 2005 Registrar

			1 - For State Registrar	te of Maryland / Dep <i>Ce</i>	artment of H		ntal Hygien	OOGE	06631
	Physici /Medic		Decedent's Name (First, Middle, Last) Ol:	ive Gustina Dav	is		Date of Death Month DEFEBRUARY	ay Year 22, 2005	3. Time of Death 2:52
	Examir Funeral		4a. Facility Name (If not institution, give street at 9415 Todd Avenue 5. Social Security Number 6. Sex 1 □ M 25	7. Age (In yrs. last birthday,		r Location of Death Fort Howar If Under 24 Hrs. 8 Hours Min.		9. Birth	nore Co. nplace (State or Foreign
	Director		216-32-5085 Usual Residence of Decedent 10a. State 10b. County	75 Yrs.			Oct. 28,1	929 Wes	t Virginia 10d. Inside City Limits
	he Maryla 28a-f shov cuilised st	ector	Maryland Baltimor			Fort	Howard	itizen of What Cou	1 □ Yes 2√√No
	s 23a or 2	Funeral Director	10e. Street and Number 9415 Todd Avenue	- Doord of Free in U.S. 42	10f. Zip Code	210	52 Un	ited Sta	tes
036	ours after de rai', or item Enaminer	ρ	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. led Forces?] Yes 2 No es, Give ar or Dates:	Was Decedent of hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specit an, Mexican, Puerto Ric Specity:	can, etc.)	Black, White Specify:	
21215-0036	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be retilised at Once.	Completed		llege (1-4or 5+) (Give	DO NOT use retired	during most of working	16b.	Kind of Business/Ir	·
and 2	d be filed ental Hygi ced other c event, II	Be	6 Years 17. Father's Name (First, Middle, Last) Benjamin Cox	H	omemaker	18. Mother's Name (F	First, Middle, Maide ence Parr	·	ne
Maryland	nd 2 shoul lith and Me 27 is mark r traumati	To	19a. Informant's Name/Relationship (Type, Prii Lloyd M. Davis /		ing Address (Street a	and Number or Rural F		or Town, State, Zi	
Baltimore,	Pages 1 a nent of Hee int: if item iry or othe		20a. Method of Disposition ↑□ Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	i from State	osition (Name of matory or other plac n Cemeters	1	_	Location - City or T	own, State Maryland
Balt	perr it. Dep rtr Imp rts any inju		21. Simulture of Funeral Service tricensee	B. (1) I	2. Name and Addres Ouda-Ruck 1922 Wise	the same of the sa	ome of Du	ndalk,Ind	C.
	Pnysician /Medical		resulting in death)	Se on each line. ARDIA Oue to (or as a consequence of):	ARRH	YTH MIA.			Approximate Interval Between Onset and Death I H D U R
	Examiner transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	CONGESTI Due to (or as a consequence of). HYPERTENS Due to (or as a consequence of):			FAILU		10 YEARS
68760,	ficate be executed physician and is the burial-transit	cal	d.	nue to (or as a consequence or):					
P.O. Box	that the death certific ed by the attending pl detached for use as t	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	∕ery Day Year
	law requires that the as been signed by th 2 should be detacht	by	Part II. Other significant conditions contributing	ng to death but not resulting in the u	, , ,	en in Part I. DISEAS à			the cause of death?
I Reco	The ate ha	Completed	DIABETES	4 ELLITUS			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	Attending Physician: The r death. c death. ctor: After this certificate his by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ♥ No Hospital 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	l: 1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury Work	4 Nursing Home			Ty)
Divis	i i i i i i	Certification:	o □ Cuiside 6 □ Could not be	. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	286	Location (Street a City or Town, Sta		al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Direction completely filled in the Funeral Direction of the Funera	Medical	(Check only 2 Medical Exeminer: Or	To the best of my knowledge, deal the basis of examination and/or in d manner stated.	vestigation, in my op	pinion, death occurred			
	To t Com	Σ	29b. Signature and title of certifier	seh, M	29c. License	3 1 number	29d. D	ate signed (Manth,	Day, Year)
	H		30. Name and address of person who complete	Ave.	Print) Dee	pak S	eth,	M.D.	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar Signature	Sports	F	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 06632 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 24, 2005 February Dona1d Bruce Dickie 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1651 Eton Way Crofton Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. Director 084-24-9687 72 Jan. 20, 1933 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or items 23e or 28e-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "natural", or items 23s or 28e-f show treumatic event, Ite Madical Exercities in ast be redified at 1 ☐ Yes 2 No Directo Maryland | Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 United States 1651 Eton Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: by Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Federal Government 4yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1651 Eton Way Crofton, Maryland 21114 Winifred A. Dickie/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages
Department of H
Important: If ite
eny injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory 2/28/2005 Odenton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donaldson Funeral Home & Crematory, P.A. Thomas Juanta K M00957 |1411 Annapolis Koad Odenton, Maryland 21113 Approximate Interval Between Onset and Death 2 years 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Prostate Cancer years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No 1□ Yes X□ No 1 Tyes the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 2 1 ☐ Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0 D41141 February 28, 2005 March ¥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dominick J. Memoli, M.D. 1406 S. Crain Highway Glen Burnie, Maryland 21061

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR 01

2005

32. Signature

			For Stata Registrar	State of Ma		artment o		ר	Reg	ene () ()5	06633
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) James A.	Doukas	M.D.	T =			2. Date of Death Month	Day / 21	Year 005	3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give: 1	ral H	OSPI tal (In yrs. last birthda) B4 Yrs.	Bal	wn, or Location The Coar of Under Oays Hours	Re (8. Date of Birth Month, Day, May 19, 19	4c. County		ice (State or Foreign y) and
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore	10c. City, Town or I						100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the ? 23a or 28a- ist be notif	Funeral Director	10e. Street and Number 1 Windemere Parku			10f. Zip Co	1 31			g. Citizen <i>o</i> f V	Vhat Countr	
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 Ia marked other than "natural", or Items 23a or 28a-f show or other traumatic event, "the Medical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1X Yes 2 □ N If Yes, Give Year or Dates:	verin U.S. 13 ○WW II	. Was Deceden If Yes, specify 1 Yes 2			offy Yes or No- lican, etc.)	Blac	e - America ck, White, et : Whit	tc.
Maryland 21215-0036	filed within 72 h Hyglene. Nher than "natu ent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5-	(Giv	edent's Usual C re kind of work o DO NOT use i	done during mo retired)		g	Medici		istry
yland	2 should be filed and Mental Hygie Is marked other raumatic event, II.	To Be (17. Father's Name (First, Middle, Last) Harry	Doukas			l	/aleri		5	Barand	
	is 1 and 2 sh of Health and Item 27 la m other traum		19a. Informant's Name/Relationship (T) Jessie D. Stahl, M 20a. Method of Disposition	.Ddaugh	ter 3438	Huntsm	an Run,	Elli	Route Number, Cott Cit		2104	2
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe <u>once.</u>		1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	E33201.1	Crest Lau	n Mem'l C 22. Name and A	Sardens Address of Faci	ility Ruck	Mi Tawson Fu MD 21204	arriotts neral H	,	
in the	Pnysician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	the death. Do not e e. 2.001/04 consequence of):	nter the mode o	of dying, such a	s cardiac or	respiratory arres	t,	1	Approximate nterval Between Onset and Death
68760,	sician and purial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Section 2) the description of the des	· 	a consequence of):							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregi □ Other (speci				23d. Dat Moi	e of delivery	/ Day Year
Records, P.	w requires that been signed t should be det	by	Part 11. Other significant conditions co	ptributing to death bu	it not resulting in the	underlying-caus	rabe:	Le S	23e. Did tobar	2 🗆 No	3 Probal	cause of death? oly 4 (Unknown sy findings available
Vital Re	iician: The law certificate has l rector, page 2 s	e Completed	25. Was case referred to medical				26 Plac	na of Death	autopsy performa	1947	orior to comp death?	pletion of cause of
ō	aling Phys I. After this funeral di	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Oatural 2 Accident investigation	lospital: 1 Alnpatier 28a. Pate of Injun (Month, Day			Other	lursing Hom	e 5 Residence 8d. Describe how		- ' ''	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	building, etc					8f. Location (Stre City or Town,	State)		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and/or	investigation, in	my opinion, de		d at the time, date	and place, a	and due to t	he cause(s)
	viti To		29b. Signature and title of tertifier	MO.			icense number 8952	6	290	Date signed	5/0	S
	10+1		30. Name and address of person who co	rales, or	1. D. 70	Mary	land	Gener	al He	spita	al	
	Sta Registr	2/1	31. Date filed (Mooth Pay, Voar) 20	105 32. Sgistra	r's Signature	grade						

		•	For State Registrar	State of	f Marylar		artment <i>rtificate</i>			ınd M	ental Hyg	jiene leg. No:	005	066	34
	Physici		Decedent's Name (First, Middle, La	•	Marie	Deah1					2. Date of Dea Month Februar	Day	5, 2005	3. Time of 3:34	
	/Medic Examin		4a. Facility Name (If not institution, giv Suburban Hospita	1				Beth	Location o			4c.	County of Death	ery	
	Funeral Director		5. Social Security Number 6. S 214-48-9456 Usual Residence of Decedent	ex □M 2⊠F	7. Age (In yrs. 58		ff Under Months	1 Year Days	ff Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb. 7,	194	9. Birth Cou 47 Wash	place (State ntry) ingtor	or Foreign
	ith the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Montgom 10e. Street and Number		10c. Ci	ty. Town or Lo	thesd	Code				10g. Citiz	zen of What Cou		City Limits s 2 X No
036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "natural", or Iteme 23e or 28a-f show any injury or other treumatic event, I're Mudical Exertifier must be neithed at ange.	by Funerai	5520 Hoover Stre 11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		2 🔯 No		Was Decedent Yes, special Yes 2	ent of Hi ify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	city Yes or No- Rican, etc.)	1	ited Sta 14. Race - Amer Black, White Specify: Wh	can Indian, , etc.	
Baltimore, Maryland 21215-0036	ed within 72 ho ygiene. her then "natur t, Ire Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)	College (1 5+	-4or 5+)	(Give	dent's Usua kind of won DO NOT uso .cher	l Occupa k done d e retired	during most)			Edu	nd of Business/I	ndustry	
yland	ould be fill Mental H harked oth	To Be	17. Father's Name (First, Middle, Last Ernest Addison D	eah1					Yat	es S	nyder				
ore, Mar	gas t and 2 sh of Heelth and If item 27 is n or other treun		19a. Informant's Name/Relationship (Yates S. Deah1/Mo 20a. Method of Disposition 1 □ Burial 2 🕱 Cremation 3 □	ther	20b. I		Hoove:	r St	reet,	Bet	hesda,_	Mary	y1 Town, State, Zipy $y1$ and $y2$ Cation - City or T	817	
Baltim	permit. Pag Department Important: any injury o	0 0 0 0	`4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices	y)	Cr	emator	ium, 2.Name and bert	Inc. d Addres A. I	s of Facility	200 rey 1	5 Funeral	Hom	nesda, M e/ Chas 20814-	sda-Ch	evv
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line.										Approxima Interval Be Onset and	tween	
8760,	The law requires that the death certificate be executed ate has baen signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b												
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 □Feta ant at time of c	al death 3	⊒Ectopic pre ⊒ Other (spe					2	3d. Date of deliv Month	ery Day	Year
rds, P	w requires that baen signed b should be deta	by	Part II. Other significant conditions of whice suffer wheel		_		,	iuse give	en in Part I.			bacco us	se contribute to I		death? Unknown
of Vital Records,		Completed	morbid a	besi	ty						24a. Was a autops perform	SV	24b. Were auto prior to co death? 1 Yes	fo noiselam	available cause of
Division of Vita	ending Phyeiclan: The eath. or: After this certificate ha the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending investigation 2 Accident 6 Could not be	28a. Date (Moni	of Injury h, Day Year)	ER/Outpatier 28b. Time o Injury	f 28	Bc. Injury Work 1 🗆 `	er: 4□ Nui	rsing Hon 2 No	8d. Describe h	ence 6 ow injury			
DIV	pitel or Att burs after d eral Direct filled in by 1		3 Suicide 6 Could not be determined	buildi	of Injury - At h	fy) 			a data and	,	City or Tow	n, State)			nber,
	To the Hospital or Attending Physicial A hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only one) 2 Medical Example (Check only one)	miner: On the ba			vestigation,	License	number	h occurre	ed at the time, d	ate and		o the cause(Day, Year)	s)
3	5		30. Name and address of person who		e of death (Item	m 23a) (Type,				•			2610 MD Z		7
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2	005	egistrar's Sign	ature	radi		, , , ,			,			

DEAHL, VATES MARIE 2/26/05

		-	For State Registrar	State of M	•	•	rtment of Herificate of L		d Mental Hy	giene Reg. No .	005	06635	
			Decedent's Name (First, Middle,	Last)	-				2. Date of D		Year	3. Time of Death	
	Physicia /Medic		Matthew	Okw	uchukwu	1	En€	ekwe F	EBRUARY	26,		10:10F M	
Acres	Examin		4a. Facility Name (If not institution, Saint Joseph				4b. City, Town, or	Location of De		4c.	County of Deat Balt	h imore	
	Funeral		5. Social Security Number		ge (In yrs. last birti		If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of B	irth (ay, Year)	9. Birt	hplace (State or Foreign untry)	
D.	Director	}	218-65-7015	X □M 2□F	61	Yrs.						igeria	
	and and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	ation					10d. Inside City Limits	
	Many -f sh	to	MD NA		Balti	mor	ce					1 X Yes 2 □ No	
	r 288	le Se	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co	ountry?	
	23a c	a D	2206 Lawnwoo	d Cir.			2120	07			Niger		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be rigitlised at or other traumatic.	by Funeral Director	11. Marital Status 1 Never Married XXMarrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ad 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	? No	If	as Decedent of His Yes, specify Cubar ☐ Yes	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nuerto Rican, etc.)	10-	14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	2 hou		15. Decedent'	s Education		Decede	ent's Usual Occupa	ition		16b. Ki	nd of Business/	Industry	
212	hin 72 9. an "na Medi	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	life. D	ind of work done d O NOT use retired))		0.55			
21	filed wit Hygiene other the	Completed	12th grade	na	Ge	ene	cal Cont					uipment	
Maryland	be filk d oth event	Be	17. Father's Name (First, Middle, L						Name (First, Middl				
yla	should be and Mental s marked o umatic eve	2	Alfred Enekwe 19a. Informant's Name/Relationsh		105	Mailine			rine Oke			Zin Codo)	
Mai	d 2 st th and 7 Is n traun												
	1 and 2 Health Iem 27 I		Patrick C. En 20a. Method of Disposition	ekwe-Brot	20b. Place of	Dispos	ition (Name of		Balti		cation - City or		
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot 2005.		1 X Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp	ecify)	St ^{cometer} Churc	_	atory or other place thews Ca Lemeter		/15/05	Ajai	lli, N	igeria	
Bal	permit Depar Impor any in		21. Signature of Funeral Service L	dmonde		Ma 14.	Name and Address arch F/1 300 Waba	H West ash Av	; /e, Balt	imo	ce, Md	21215	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each I	d the death. Do n line.	not ente	r the mode of dying	g, such as card	diac or respiratory	arrest,		Approximate Interval Between	
6	Physician		Immediate Cause (Final disease or condition	CARDIA	ARRES	TD	UE TO A	RRHYT	HMIA		3	Onset and Death	
	/Medical Examiner		resulting in death)		s a consequence o		AND AREA ON ABOUT A A A						
	<u> </u>	er	Sequentially list conditions, if any, leading to immediate	D	CARDI		UPATHY					YEAR	
	ited	mine	cause. Enter Underlying Cause (Disease or injury		INSUEE		-51115					a gravit gay gary pers	
Ć,	ficate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last		s a consequence o						t	YEARS	
8760,	ysicia y bur	dlcal		d									
9	rtifica ng ph as th		IF FEMALE:										
.O. Box	that the death certific led by the attending p detached for use as:	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year	
Δ.	that ned by deta	by Pr	Part II. Other significant condition	ns contributing to death	but not resulting in	n the un	derlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?	
rds	quires in sign uld be								_ 1	Yes 2	No 3□Pr	obably 4 Unknown	
Records,	The law requires that the rate has been signed by the page 2 should be detache	ompleted							24a. Wa aut per 1 Yes	opsy formed?	24b. Were au prior to death?	atopsy findings available completion of cause of	
Vital		BeC	25. Was case referred to medical examiner?						Death (Check only				
of V	Physician: this certific ral director,	Tof	1 ☐ Yes 2 No		ient 2 ER/Ou			4 Nuisiii	g Home 5 Re			cify)	
n o		on:	27. Manner of Death 1 ★Natural 5 □ Pending			Time of njury	28c. Injury Work	</td <td>28d. Describe</td> <td>how injur</td> <td>y occurred</td> <td></td>	28d. Describe	how injur	y occurred		
sio	tent leat tor: the	icati	2 Accident investig	ot be 280 Place of Ir	njury - At home, fa	ımı stra		Yes 2 □ No	28f Location	(Street an	d Number or Ri	ıral Route Number,	
Division	al or Attend s after death il Director:	Certification:	4 ☐ Homicide determi	ned building, e	etc. (Specify)	uiii, siie	et, factory, office		City or T	own, State)	ng 110gto Hombor,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (g Physician: To the bes examiner: On the basis and manners	of examination and								
	To the within 2 To the complet	Me	29b. Signature and title of Certifier	111			29c. License	number		29d. Dat	e signed (Mont	h, Day, Year)	
	1		1/1/12	8			04037	Lean Lean		1/2	6/200	75	
	N		30. Name and address of person	who completed cause of	death (Item 23a) ((Type, F	Print)			,			
	-	55	IOHN C. LASCH		76.71 rar's Signature	OS	LER DRI	VE TO	WSON, M	ARYL	AND 21	204-7582	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0				1						
	- Indigioti		MAN V	T 7003	offer B	1	porte						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Man		artment of I rtificate of			jiene 0 0 5	06636	
	Physici		Decedent's Name (First, Middle, Alice	J.	Ebr	on		2. Date of Dea Month 2	th Day 2005	3. Time of Death 12:00p M	
	/Medio Examin		4a. Facility Name (If not institution,	give street and number)			or Location of Deatl	1	4c. County of Deat		
	LAGITI		Johns Hopkins	Hospital		Balti	more		NA		
	Funeral Director		5. Social Security Number 216-05-0138	3. Sex 7. Age (I	n yrs. last birthday) 99 Yrs.		If Under 24 Hrs.	(Month, Day	Year) 9. Birti	nplace (State or Foreign untry) D	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-1 show ha Madical Examinat must be notitied at		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	MD NA		Baltimo	re				Y Yes 2 No	
	if th	Sire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?	
	23e	a	127 West Henr	ietta Stre			21230		U.S.A.		
	tems	an a	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecity Yes or No- o Rican, etc.)	14. Race - Ame Black, White		
36	or It	by Fu	1 Never Married 2 Marrie	If Yes, Give		1 ☐ Yes 2 🗓 No	Specify:		Specify:		
21215-0036	tural'	d b	3√ Widowed 4 Divorced	Year or Dates:	100 Date	death Herel Occur			10h Kind of Business (
<u>1</u>	"naf	iete	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wor ed)	king	16b. Kind of Business/I Gatch Wir	,	
7	withi ene. than	Completed	Elementary/Secondary (0-12) 5th grade	College (1-4or 5+)	1	elder	,		Goods Com		
	filed Hygir other ent,	Ö	17. Father's Name (First, Middle, La	ist)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)		
<u>a</u>	Mental arked o	To Be	James Johnson	1			Cora J	ones			
Maryland	should Ind Meni	-	19a. Informant's Name/Relationshi		19b. Maili	ng Address (Stree	t and Number or Ru	ıral Route Numbei	, City or Town, State, Z	ip Code)	
	1 and 2 Health a iem 27 is		Sheila Moore-G	rand-Daugh	ter 173	7 West	North A	ve, Bal	to, Md 2	1217	
Baltimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or	Fown, State	
Ë	Pages nent of I nnt: If its iry or o		XXBurial 2 Cremation 3 4 Donation 5 Other (Spe	i □Removal from State			ery 3/2	/05	Baltimore	, Md	
ati	permit. Page Department of Importent: If any injury or once.		21. Shature Fineral Service L	_		2. Name and Addre	-	_	timore, Md.		
ä	Depar Impo		Nat 13.	Johnson	1	March F.	H. West		abash Ave.		
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	omplications that caused the nly one cause on each line.	-		_			Approximate Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to for as a c	onsequence of):	unon	ary t	dem	2	day	
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (of as a consequence of): Due to (of as a consequence of): Due to (of as a consequence of): Due to (of as a consequence of): Due to (of as a consequence of):							
	cate be executed only sician and the buriat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		U		Q				
Ó	e exerian ar	EX	resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	death certificate be executed e attending physician and of for use as the burrat-transit	dicai		d							
ý X	death certifica attending ph for use as the	Me	IF FEMALE:	OZa If was outcome of							
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnanc	:у		23d. Date of deliment	very Day Year	
o O	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at tim 9□ Unknown	e of death 5L	Other (specify) _		-			
0	that the de ed by the detached		Part II. Other significant condition	s contributing to death but r	ot resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tol	pacco use contribute to	the cause of death?	
Records,	The law requires that the ste has been signed by thoage 2 should be detache	ed by						1 🗆 Ye	es 2□No 3□Pro	bably 4 Donknown	
000	aw re	Completed						24a. Was a		opsy findings available	
ď	The la	mo						autops perform		ompletion of cause of	
ta	sician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only on	**		
>	nystc Nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 TER/Outpatier	nt 3□ DOA Ot	her: 4 Nursing H	ome 5 Reside	ence 6 Other (Spec	ify)	
0	ding Phys		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	f 28c. Inju Wo	ry at	28d. Describe ho	ow injury occurred		
0	Attending Physician: or death. ector: After this certified by the funeral director, I	atic	2 Accident investiga				Yes 2 No				
Division of Vital	or Attendation death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Injury building, etc. (\$	 At home, farm, str Specify) 	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physician: To the best of m	ny knowledge, deat	h occurred at the ti	ime, date and place	, and due to the c	ause(s) and manner as	stated.	
	the H in 24 the Fi	ledicai	one)	kaminer: On the basis of ex and manner stated	dilliauon and/or in						
	To T com	Σ	29b. Signature and title of certifier	7		29c. Licens	se number	2	9d. Date signed (Month	, Day, Year)	
			BX	d.			1720	2	2/28	105	
	1		30. Name and address of person w	no completed cause of death	h (Item 23a) (Type,				1	/	
			31 Date filed (About And	M. D. 10157 32. Raistrar's	Signatures	NA AV	E BAL	TIMO	RE MO	2/222	
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Hagistrar's	w J.	porce					

			1 - For State Registrar		arylan	d / Depa	artme		lealth a	and M		ene g. No.2 (05	06637
н	Physic	an	Decedent's Name (First, Middle, Las	t)							Date of Death Month	Day	Year	3. Time of Death
	/Medi			ie Ert							February	7 27,	2005	3:15p M
	Examir	ner	4a. Facility Name (If not institution, give					, Town, or		of Death		4c. Coun	ty of Death	
			Chesapeake Hospic			to and the last of the		inthi er 1 Year		24 Hrs		Anne	Arun	
	Funeral Director		5. Social Security Number 6. Security Number 1	9X □M 21XIF 7. AG		last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day,			place (State or Foreign ntry)
			215-28-9826 Usual Residence of Decedent		75						Dec. 20,	1929	<u>M</u>	laryland
	laryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						- 1	10d. Inside City Limits
	Mar s-f st	tor	Maryland Anne An	unde1		Harm	ans							1 ☐ Yes 2 🖔 No
	h the	Director	10e. Street and Number					ip Code		-	10	g. Citizen of	What Cou	ntry?
	th wit	aiD	12 Hanford Drive					210	77			Unit	ed St	ates
	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or flams 23a or 28a-1 show avent, the Mudical Exertinat Letter Intified at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dec	edent of Hi	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		ce - Ameri	
9	or It	Fu.	1 Never Married 2 Married	1 ☐ Yes 2 X				2X□ No	Specify:		nican, etc.)		ack, White,	etc.
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			1 4 1 63	25.110	Specify.			Speci	w. W	hite
7	nat	Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece (Give	dent's Us kind of w	ual Occupa ork done d use retired	ation <i>Juring mo</i> s	t of worki	ing 16	6b. Kind of I	Business/In	dustry
12	withir nne. than	ш	Elementary/Secondary (0-12)	College (1-4or	5+))			-		
22	iled Tygi ther nt,		17. Father's Name (First, Middle, Last)			wa	itre	SS	19 Moths	ar's Name	(First, Middle, Ma		staur	ant
auc	ntal h	Be	Asa Biggs							lsie				
Z	2 should be f and Mental b Is marked of sumatic ave	²	19a. Informant's Name/Relationship (7	ivne Print)	_	10h Maille	a Adden	o (Chront o			Mary		ark	
Maryland	nd 2 saith an 27 is i			,		65.00		8.5			Il Route Number, (•		
	He He	l li	John Thomas Erbe/1 20a. Method of Disposition	usband	20b. P	12 H	anfo	rd Dr	ive	Harn	aus, Mar	yland oc. Location	2107	7 State
ē	00		1 Burial 2 Tremation 3	Removal from State		lace of Dispo							•	
Baltimore,	# 문 분 등 .		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		W • .	Arunde								aryland
Ba	permit. Departri Importa any inju				240	Ď	onal	dson	Funer	al E	lome & Cr	emato	ry, P	.A.
			23a. Part 1. Inter the disease, or comp shock, or heart failure. List only	lications that caused		095/ 1	411	Annap	olls	Roac	l Odento	n, Ma	rylan	d 21113 Approximate
	Physician /Medical Examiner	ıer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. <u>Metas</u> Due to (or as	tation a consequent	c Lunguence of): Smoki	Can							Interval Between Onset and Death 2 years
68760,	e law equires that the death certificate be executed has been signed by the attending physician and e 2 st ould be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):								
.O. Box	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal	death 3□	lEctopic p	pregnancy pecify)					ate of delive	ery Day Year
٦,	es that igned to be deta	by P	Part II. Other significant conditions co	ntributing to death b	ut not resu	ilting in the ur	nderlying	cause give	n in Part I.		23e. Did toba	cco use con	tribute to th	ne cause of death?
ğ	equire en sig ould b	pa	Atherosclerosis								1 ₹ Yes	2 🗆 No	3 🗆 Prob	ably 4 Unknown
Vital Records,	s bee	Completed									24a. Was an	24b.	Were auto	psy findings available
Ž.	_ 0 a	mo									autopsy performe 1 Yes 2	d?	death?	mpletion of cause of
ta		0	25. Was case referred to medical						26. Place	of Death	(Check only one)	ANO	1 ☐ Yes	2□ No
>	ya Si Si	0 8	examiner? 1 ☐ Yes 2 [XNo	Hospital: 1 ☐ Inpatie	nt 2 🗆 1	ER/Outpatien	t 3 🗆 D	OA Othe	_		ne 5 Residenc	e 6 🕅 Ott	ner (Snecifi	Hospice
J Of		L:u	27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time of		28c. Injury Work			8d. Describe how			любрисс
ō	Attending I r death. ector: After by the funer	atio	1 XNatural 5 Pending 2 Accident investigation	(INDITUT, Da)	y rear)	Injury	М		r 'es 2⊡1	No				
Division	ial or Attend s after death al Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At ho	me, farm, stre	eet, facto	y, office		2	28f. Location (Stree City or Town, S	et and Numi State)	ber or Rura	l Route Number,
	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in the completely filled in the complete or a second to the c	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	sician: To the best of the basis of and manner sta	' examinat	wledge, death ion and/or inv	occurred	at the time	e, date and inion, deat	d place, a th occurre	and due to the caused at the time, date	se(s) and man	anner as st and due to	ated. the cause(s)
	To the within 2 To the complet	为	29b. Signature and title of sertifier				29	c. License	number		29d	. Date signe	ed (Month, I	Day, Year)
}	01		lufresse	ish				D025	134		F	ebruai	y 28	, 2005
i	0	1	30. Name and address of person who	leted cause of d	eath (Item	23a) (Type, I	Print)							
_/			Carol A. Pressey	M.D. 31	69 B1	averto	on St	reet	<u>#10</u>	1_Ed	gewater.	Marv1	land 3	21037
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 200	32 Registra	ar's Signat	y do	arte	,	, ,,=-0		0		- OF 2448	-2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 7,8 per FH, G845 07/29/05dhb Certificate of Death 1 - For State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** February 26, Hierlie Enongene 2005 10:30a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir(19/17/89) 9. Birthplace (State or Foreign (Months) Days | Hours | Min. | (Month, Day, Var) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🛣 F 15 Yrs. unknown unknown Director unknown UNY Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "neturel", or Items 23a or 28e-f show treumatic event, the Madical Examinar mast be multiled at UNK1 Yes 2 No unknown unknown unknown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unknown unknown unknown e filed within 72 hours after death val Hygiene. I other than "neturel", or Items 23s Funeral LINIL 12. Was Decedent Ever in U.S. Armed Forces? \\\\\ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Place of Disposition (Name of 20c. Location - City or Town, State Washington, DC unknown 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) unknown 22. Name and Address of Facility Johnson and Jenkins Funeral Home 21. Signature of Funeral Service Ligensee 716 Kennedy St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Futracranial Hemorrhage /Medical Due to (or as a consequence of): Examiner AIDS Cerebrovasulitis Sequentially list conditions, I any leading to him edials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 □ No ed by the a 9 Unknown 9 XUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 🔀 No 1 ☐ Yes I or Attending Physicien: after death. Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6XOther (SpecifyHospice 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To 28b. Time of Injury funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 1041218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20854

DHMH 17 Rev 1/2001

State

Registrar

Charles Harrison 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1232 Month **Physician** 2005 LODONA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Baltimore Marit Samerita Hospital N/A Good an 8. Date of Birth (Month Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Yrs. 6. Sex 5 Social Security Number **Funeral** Days Min Months 1 □ M 579-58-7126 D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 2 should be filed within 72 mounts and Mental Hygiene 1 and Mental Hygiene 1 far marked other than "naturel", or items 23s or 28s-f show 7 is marked other than "naturel", or items 23s or 28s-f show 7 is marked other than 1 and 1 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21208 USA 25 EVAN WAY Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER other treumatic avent, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental MOROVITZ KRAFT EVA BENJAMIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if Item 27 is 25 EVAN WAY - BALTIMORE, MD 21208 DONALD EDLOW / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 5 permit. Page Department of Important; if any injury or CHIZUK AMUNO ARLINGTON 2/27/2005 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Moura Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 18 months?

1 Yes 2 No
9 Unknown Month Day ō 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 26. Place of Death (Check only onle) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes Certification: To this within 24 hours after death.

To the Funersi Director: After thi
completely filled in by the funeral i 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 Survere + who completed cause of death (Item 23a) (Type, Print) Tood 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 25, 2005 Edith Irene Epstein 5:00 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Center Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 17, 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2♥F Director 214-18-6856 83 Yrs Maryland Usual Residence of Decedent with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at Baltimore MD Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6660 Apt. C Sanzo Road 21209 U.S.A. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "naturel", or Item any injury or other treumatic event, the Medical Examinat Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) С. Hans Anderson Laura Η. Ringbom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7401 Kalton Ct., Pikesville, MD Madeline C. Rosenthal-Executor 21208-5829 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State A □ Donation 5 ⋈ Other (Specify) Entombment Lorraine Park 3/2/05 Baltimore, MD 21. Signature of Funeral Service Licensee Utilliam G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and hed for use as the burial transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death Month Day Year 5 Other (specify) detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes No certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner' Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🍇 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 130,931 Name and address of per on the completed cause of death (Item 23a) (Type, Print) ORFUENE IREC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem#20b, perFH, C841-3/3/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DayRTH 3. Time of Death **Physician** FEIM RUTH TEBRUARY 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center No RTA WES 70 190561 Ka If Under 24 Hrs. IT, marc 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 206 - 20-7930 Usual Residence of Decedent 1 M 22 Months Hours Director C with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Is marked other than "naturel", or Items 23e or 28e-f show treumatic event, Ins Medical Examinar must be notified at treumatic event, ins Medical Examinar must be notified at Director Limore 1 → Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "was 215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filted within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or item any injury or other treumatte. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. 3 ₩idowed 4 Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mc Kae ames ပ Ickae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Harrison Mc Kae H.I. 02909 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State ◆□ Donation 5 □ Other (Specify) Tiona 375/2005 21. Signature of Funeral Service bicens 22 Name and Address of Facility S Funeral Home oseph L. Russ Full. 2222 W. North Ave Baltimore Md. 21216 Approximate Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed LEREBROVASCULAR Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 98 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 **N**No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 💢 No 1 Yes or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 No 1 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. D te of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending Injury thours after death.

unerel Director: After ally filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel E To the Hospitel 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number malta m.D D41410 tebruery 24 30. Name and ad ress if person who completed cause of death (Item 23a) (Type, Print) 106140ER MEHTR HOSPITAL CENTER RANDALLSTOWN MO MORTHWEST

DHIVIH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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2005

32. Restrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. Nd. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Foracappo, Sr. Jerome Α. February 24, 2005 10:00 P M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 3603 Parkhurst Way If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 28, 1924 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F Months 80 219-16-8726 Director Usuel Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, it is Madical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 3603 Parkhurst Way U.S.A. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ğ 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas and than Elementary/Secondary (0-12) College (1-4or 5+) Supervisor - Line Clearance Electric 12th Grade if Health and Mental Hygi Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Foracappo Helen Winhelder Sam ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 High Plains Drive, Bel Air, MD 21014 (son) Jerome A. Foracappo, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permil. Pages to Department of Himportant: If Ite eny injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2/28/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Buin a Wi 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition esperatory **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ut as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Xes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Alatural 5 Pending within 24 hours after user.

To the Funeral Director: After a function of the investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 296 Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 026002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sulc 409 32. segistrar's Signature 31. Date filed (Month, Day, State 2005 0 1 Registrar

				1 - State Registrar State of Maryland / Departr	ment of Health a	nd Mental Hy	giene Reg. No.	05 06643
		a.		1. Decedent's Name (First, Middle, Last)	-	2. Date of De	eath	3. Time of Death
		Physici /Medio		Andrew Trice Flem	ning	Month Februa	ary 24,	Year 2005 10:50 A ^M
		Examir			. City, Town, or Location o	Death	4c. County	
				Gilchrist Hospice	Towson			imore
		Funeral		15th 2DE	Under 1 Year if Under 2 onths Days Hours	Min. (Month, Da	th ay, Year)	Birthplace (State or Foreign Country)
		Director		711-10-2314 82 Yrs. Usual Residence of Decedent		Nov.	22,1922	Virginia
		land ow		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
		Man, Fied	ţō	Maryland Baltimore		Perry Hall	1	1 ∐ Yes 2 ∑SNo
		r 28g	Director		Of. Zip Code	TCITY HAT	10g. Citizen of V	/hat Country?
		th wit		20 Bangert Avenue		21128	United	d States
		ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 15. Was Decedent Ever in U.S. 15. Was If Yes	Decedent of Hispanic Orig s, specify Cuban, Mexican,	in? (Specify Yes or No)- 14. Race	- American Indian,
	36	or It		1 ☐ Never Married 2 ☑ Married 1 ☑ ★es 2 ☐ No If Yes, Give 1 ☐ \)	Yes 2☑ No Specify:	Tuono moan, etc.)	Specify	k, White, etc.
	Ö	hours ural',	d by	3 Wildowed 4 Divorced Year or Dates: WWII				White
	15-	in 72	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most IOT use retired)	of working	16b. Kind of Bu	siness/Industry
	12	with iene. thar	omp	Elementary/Secondary (0-12) College (1-4or 5+)	cious Metal		Fne	graving
	p	filled I Hyg other	BeC	17. Father's Name (First, Middle, Last)		's Name (First, Middle		
	/lar	uld be Venta Venta Irkad Itic ev	To E	Andrew Hamden Fleming		Myrtle Gra	aves Fler	ning
	lan	2 sho and I is me			Idress (Street and Number			State, Zip Code)
	≥,	and lealth m 27 har tr			ingert Ave.		·	1128
	O.	ges 1 t of H If ita or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetary, cremator,	y or other place)	Date	20c. Location -	City or Town, State
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, If a Modical Examinet must be notified at once.			ervice Corp.			, Maryland
	Ba	permi Depar Impor any ir		792	me and Address of Facility -Ruck Funera 2 Wise Ave.	Dundalk,	Maryland	
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e mode of dying, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death) a. Luy Cuncu				Onset and Death
		/Medical Examiner		Due to (or as a consequence of):				
3	В		J.	Sequentially list conditions, and any Japaning to immediate by Due to (or as a consequence or).				
50/AM	1	uted I Insit	min	cause. Enter Underlying Cause (Disease or injury				
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2.24	0.	t the dea by the a tached fo	hysician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown	er (specify)		Mon	th Day Year
0	۵.	that the ed by detac	۵.	Part II. Other significant conditions contributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
	rds,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	ed by			A		3 ☐ Probably 4 ☐Unknown
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ANSAEW	H.						rmed? de	rior to completion of cause of eath? Yes 2 No
32	ita	Phyaician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	26. Place of	of Death (Check only o	/	
3	of V	Phyaic this ce al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3		ing Home 5 🗆 Resid	dence 6 the	(Specify OSPICE
1		ding Ph h. After th funeral	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work?		now injury occurre	d
5	Sio	tand leath tor: / the f	cat	€ Accident investigation M 3 Suicide 6 Could not be 200 Rises of Injury At home form should be				
LE MING	Division	l or Attano after death Director: in by the	ertification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, la building, etc. (Specify)	actory, office	28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural Route Number,
73	_	a Hospital of 24 hours at a Funaral Dietely filled i	0	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and	place, and due to the	cause(s) and man	ner as stated
E		To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	ation, in my opinion, death	occurred at the time,	date and place, a	nd due to the cause(s)
		To the To the Comp	ž	29b. Signarure and title of certifier	29c. License number	1	-	(Month, Day, Year)
	•				D58003		Februar	(Month, Day, Year)
		641		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		110 7:1	0/4	
		Sta	te.	AAN CAPURS W GGO! N COWCS 31. Date filed (Month, Day, Year) 32. Rejistrar's Signature)	1 ,0=00(=)	10-11-01	77	
		Registr		MAR 0 1 2005 32. Resistrar's Signature.				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Feb. ^{Day} 2005^{Year} 22 2:40am Ruth A. Finneyfrock 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll County Long View Nursing Home Manchester 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 □ J 217-10-0879 87 Yrs MAryland May17,1917 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 BensMill Court USA 21136 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifWhite 3 ₩ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HollyHillCemetery

r then "netural", or itams 23e or 28e-f ahow the Medical Exercines I was be notified at Baltimore, Maryland 21215-0020

Physician

Examiner

10a. State

MD

Director

Funeral

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Be Completed

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Funeral

Director

/Medical

/Medical

Physician Examine To the Hospital or Attanding Physician: The law requires thet tha death certificate ba axecuted physician a within 24 hours after death.

To the Funeral Director: After of complataly filled in by the funer

Division of Vital Records, P.O. Box 68760,

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	1. Luci		O Mace Ave. Baltin									
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the mode of the cause on each line.	dying, such as cardiac or respiratory arrest,									
	Immediate Cause (Final diseese or condition	DC++ heim	ic Demando									
e	resulting in death)	Due to (or as a consequence of):										
Examiner	Sequentially list conditions,	b. Due to (or as a consequence of).										
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/Med	resulting in death) Last	d										
Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Medical Certification: To Be Completed by			24a. Was en auto performed?									
Comp			1 ☐ Yes 2									
æ	25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
٩	1□ Yes 2☑ No	TE Impatient 2E EN/Outpatient 3E DOA	Other: 4 Nursing Home 5 Residence									
ation:	27. Manner of Death 1. Naturel 5 □ Pending 2 □ Accident investigation	M 1	jury et 28d. Describe how inju lork? □ Yes 2 □ No									
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	e 28f. Location (Street e City or Town, State									
edicai (29a. Certifier (Check only one)	ysicien: To the best of my knowledge, death occurred et the illner: On the basis of examinetion and/or investigation, in my and manner stated.	time, date and plece, end due to the cause(s y opinion, death occurred at the time, date an									
ž	29b. Signature and title of certifier	29c. Lice	nse number 29d. Da									
		0	33165									

22. Name and Address of Facility ConnellyFuneralHomeofEssex

2/26/05 Baltimore MD

20c. Location - City or Town, State

more MD 21221 Approximete Interval Between Onset and Deeth

Della Mae Stone

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

18 BensMill Court Reisterstown MD

use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to completion of cause of death?

P No

1 ☐ Yes 2 € No

6 ☐ Other (Specify)

ry occurred

nd Number or Rural Route Number,

and menner as steted d place, and due to the cause(s)

te signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

George Washington Hamilton

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

/ daughter

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Della Rott

20a. Method of Disposition

23 05 1,507,5

31. Date filed (Month, Day, Year) State Registrar

32. Registrar

DHMH 16 Rev 6/95

-0	1330			State of Mary	land / Den	artment of H	loolth and A	Montal Hyair	ne Legible.	
			1 - State Registrar	Otate of Mary		rtificate of L		-	2000	06615
			Decedent's Name (First, Middle	a, Last)		rimodic of L	Jean	2. Date of Death	J. No. UUJ	3. Time of Death
	Physici /Medi		Daniel Jakon	Fraunhoffer				Februar	y 21, 2005	15:45 M
	Examir		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death	TODIAGE	4c. County of Death	
			Parking lot Wa	iterford park		Pasadena	l		Anne Arur	ide1
	Funeral		5. Social Security Number	4 50 M O D E	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
	Director		218-68-1047 Usual Residence of Decedent	4	9 Yrs.			Nov. 14,	1955 Mary	land
	yland Jow		10a. State 10b. County	10c	c. City, Town or Lo	ocation				10d. Inside City Limits
	Man a-f eh	to	Maryland Anne	Arunde1	Pasaden	а				1 ☐ Yes 21 No
	th the	Director	10e. Street and Number			10f. Zip Code		10g	. Cîtizen of What Cou	ntry?
	within 72 hours after death with the Maryland ene. then "natural", or liems 23a or 28a-f ehow he dical Exic oil ret mast be notified at	ral	1725 Bayside	Beach		211	.22		U.S.	Α.
	after dea or Items	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	rs afte	y F	1 Never Married 2 A Marri 3 Widowed 4 Divorced	ied 1 ∐ Yes 2 ⊠ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	,,	Specify:	
8	2 hou	Completed by	15. Decedent		16a Decer	dent's Usual Occupa	ition	10	V	hite
215	hin 72 in "in	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5+)	(Give	kind of work done di DO NOT use retired)	uring most of worki	ng	b. Kind of Business/In	austry
7	od wit giene er the	Com	12	College (1-401 5+)		chinist			fanufactur:	ing
p	al Hy	Be (17. Father's Name (First, Middle,	·			18. Mother's Name	(First, Middle, Ma		0
yla	ould to Ment arke	70	Jakob K. Frau				Anna Har	rter		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or II any injury or other traumatic event, the Medical Extrainone.		19a. Informant's Name/Relationsh						city or Town, State, Zip	
	1 and Healtl		Anna Appell () 20a. Method of Disposition	Sister)	8925	Old Fred	erick Roa		tt City, M	
Baltimore,	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation			sition (Name of natory or other place	ı		c. Location - City or To	own, State
Ħ	artme artme ortani injury		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Tuneral Service L			pherd Cem . Name and Address		5-05 E	llicott Ci	ty, MD
ä	permi Depa Impo any ir		V Donne	Delsen	137 W	itzke Fun	eral Home	of Cato	nsyille, I	nc. land 21228
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	/Medical		resulting in death)	Due to (or as a con.		nshot	wound	OI HEL	la	
	Examiner		Sequentially list conditions	b. ———						
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687	ficate g phys	edic		d						
Вох	leath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of delive	n/
о. С	death e atte	hysician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F		Ectopic pregnancy Other (specify)			1	Day Year
P.0.	at the by th	Phys	9 Unknown	9□ Unknown						
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	þ	Part II. Other significant condition	s contributing to death but not	resulting in the un	derlying cause giver	n in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Records,	w require been signatured should b	Completed						1 🗆 Yes	2 □ No 3 □ Prob	ably 4 DUnknown
ခင	e taw has b	mple						24a. Was an autopsy	prior to con	sy findings available
	ician: The t certificate ha rector, page:							performed 1 Yes 2	l? death?	2 🗆 No
Vita	Physician: rthis certificaral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	77		26. Place of Death			A+ 00000
Division of	9 Physe er this eral dir	-	27. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of	3☐ DOA 28c. Injury a Work?		ne 5 □ Residence 8d. Describe how in	6 Other (Specify	At scene
0	Attending In death. ector: After by the funer	atio	1 □ Natural 5 □ Pending 2 □ Accident investiga		Forma	Work? ○M 1 ☐ Ye		Subjec	1 / 1 1.	self
N N	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be	t home, farm, stre	et, factory, office	2	8f. Location (Street	and Number or Rural	Route Number,
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	Hospital or 24 hours afte Funeral Dir itely filled in	edical	29a. Certifier 1 ☐ Certifying (Check only 2 ☑ Medical E	Physician: To the best of my k xaminer: On the basis of exam	knowledge, death ination and/or inve	occurred at the time	, date and place, a	nd due to the cause	e(s) and manner as sta	ited.
	ple ple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License r				
	5 <u>4 8</u> ±		101110	LA 1000	A	OCME	10/11/061		Date signed (Month, E	
1	d	-	30. Name and address of person w	to completed cause of docth (tem 23a) /Truss D			Fe	ebruary 22	, 2005
	(CAROL H +	FLI AN MI	төш <i>23а)</i> (турө, Р		enn Stree	t Baltin	nore, Mary	and 21201
	Stat	e	31. Date filed (Month, Day, Year)	32. Resistrar's Sig	gnature			C Darem	iore, rary.	Land 21201
	Registra	r	MAR 0 1	2005 Maria	J. A.	book				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kathleen Fricker February 2005 8:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mariner Heanlth of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 26, 1914 **Funeral** Birthplace (State or Foreign Country) Hours Days Min. 1 ☐ M 2 🔯 F 90 086 28 9267 Director England Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f show Maryland | Director Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or items 23a or? 7355 E. Furnace Branch Road 21060 England Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Completed by Specify: 3 Widowed 4 □ Divorced White The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Harrison Ada Hopkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 623 North Lakewood Avenue Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Linda Chmura / Niece item 27 other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3/3/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CR ONOU 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4∏Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 PNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 🔲 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 No Other: Certification: To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Mann f Death 28b. Time of After 28d. Describe how injury occurred 1 atural 5 Pending death. tours after death, neral Director: A filled in by the fu 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral D 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) nd of certifier 29b. Signat ٥ 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ton 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2005

Gosa

	·		1- For State of Mar		artment of Health and M rtificate of Death	Mental Hygien	211115 11664/
	Physic /Medi		1. Decedent's Name (First, Middle, Last)		FETZ	2. Date of Death Month D FEBRUARY	25 2015 2019 M
*	Exami		4a. Fecility Name (If not institution, give street and number) JOHNS HOPKINS HOSPIT	4 4	4b. City, Town, or Location of Death 13 ALTIMORE		lc. County of Deeth BALTIMORE CITY
	Funeral Director			n yrs. lest birthday) 55 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Yea FEB 23. 1	9. Birthplace (State or Foreign Country) 950 CALTFORNIA
	Maryland f show	ō	Usual Residence of Decedent	Oc. City, Town or Lo ODENTON	cation		10d. Inside City Limits 1 □ Yes 2 X No
	after death with the Marylan or Iteme 23s or 28s-f show other mast be notified at	i Director	10e. Street and Number 1304 GREYSWOOD ROAD		10f. Zip Code 21113	10g. C	Citizen of What Country?
036	72 hours after death with the Maryland natural', or iteme 23s or 28s-f show areal Exar, thermal be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates 166	A TD3457	Was Decedent of Hispanic Origin? (Sp I Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event, the McGrcal Exp	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	Kind of Business/Industry
and 2	id be filed vental Hygie ked other t ic event, Ib	Be	17. Father's Name (First, Middle, Last) JOHN FETZ	MASTE		e (First, Middle, Maide	ARMY on Sumame)
Maryland	nd 2 shoul lith and Me 27 is mark r traumati	은	19a. Informant's Name/Relationship (Type, Print) WENDY FETZ / WIFE		g Address (Street and Number or Run		
Baltimore,	it. Page riment c ritent: If njury or		20a Method of Disposition	20b. Place of Dispose cemetery, crem CHESAPEAK CEN	GREYSWOOD ROAD, Of sition (Name of natory or other place) E CREMATION TER Name and Address of Facility	Date 20c. I	Location - City or Town, Stete VENSVILLE, MD SECOND AVE. S.W.
Ba	Depa Depa Impo any ii		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	411 SI	NGLETON FUNERAL HO	OME, P.A. (GLEN BURNIE, MD 2106 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) A Due to (or as a condition death)		C CANCER		Onset and Death 3 mos.
,8760,	Attending Physician: The law requires that the death certificate be executed rideath controlled. Actor: Attenthis certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	dicai Examiner	Sequentially list conditions, if any, loading to unmodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the co				
P.O. Box 6	that the death certifica ed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant at time of the past 12 months? 4 Pregnant at time of pregnant at time of the past 12 months?	Fetal death 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but no LIVER FAILURE	ot resulting in the un	derlying cause given in Part I.	I	use contribute to the cause of death?
I Reco	The law rate has be page 2 sho	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita Vita	ysicien: The is certificate hadirector, page	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient		26. Place of Death		
Division of Vital Records,	anding Phys ath. or: After this he funeral di	ertification; To	27. Manner of Death 1 Natural 2 Accident 1 Phatural 1 Natural 2 Accident 1 Phatural 1 Natural	2 ER/Outpatient 28b. Time of Injury	3 DOA 4 Nursing Hor	me 5 Residence 28d. Describe how inju	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fa	0	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	pecify)		City or Town, State	
	the Hosp in 24 hou the Fune ipletely fil	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of m 2 ─ Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death mination and/or inv	occurred at the time, date and place, a estigation, in my opinion, death occurred.	and due to the cause(s ed at the time, date and	and manner as stated. d place, and due to the cause(s)
	Volt Con	2	29b. Signature and title of certifier M T		29c. License number RES-000		Rude signed (Month, Day, Year)
	Sta	10	30. Name and address of person who completed cause of death ROBIN VELDT Johns Hop 31. Date filed (Month, Day, Year) MAR 0 1 2005	KINS HOS			21287
20	Domina		MAR 0 1 2005	1334SL			

DHMFI 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artmen rtificate			and M	,	Reg. No	UUU.		548
	Physici	an	1. Decedent's Name (First, Middle, Last Michael L. Fay)					:	2. Date of D Month Februar		, 200°		e of Death
	/Medie Examir		4a. Facility Name (If not institution, give Manor Care Ruxton			4b. City, Tows		Location of			Ba	County of E	Death	<u> </u>
	Funeral Director		5. Social Security Number 218-20-1349 6. Se	x 7. Age (<i>in yn</i> 94	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D May 22	irth Pay, Year , 19	20 111	Birthplace (Sta Country) Ingary	ite or Foreign
	Maryland a-f show	tor	10a. State 10b. County MD Baltimore		City, Town or Lo	ocation								e City Limits
	th with the 23a or 28 ubt te not	ai Direc	10e. Street and Number 905 Southerly Roa	d Unit 1		10f. Zip 212					10g. C	tizen of Wha	t Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itame 23a or 28a-f show says injury or other traumatic event, the Medical Exampliar must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	0-		American Indian White, etc. White	n,
21215-0036	d within 72 h giene. or than "natu the Mudicu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life. Teach	kind of wor DO NOT us	k done a	lurina mosi	t of worki	ing		and of Busine	,	
Maryland	tould be filed and Mental Hygie narked other natic event, it	To Be	17. Father's Name (First, Middle, Last) Michael Fay					unkno	wn	e (First, Middle Mren	er			
Ma	ulth and 27 is n		19a. Informant's Name/Relationship (T) Edgar G. Cumor, J		19b. Mailir 1 901									
ore,	of Hea of Hea fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b.	Place of Dispo					Date			or Town, State)
altimore,	tment tant: I		*4 □ Donation 5 □ Other (Specify)	Hi]	lltop S	ervic	e Co	rp. 3)5		son, N		
Bal	Depar Impor eny ir		21. Signature of Fundal Service Licens	Drug/		2. Name and UCK To				Home			ork Road MD 212	
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	mer i				cardiac o	or respiratory :	arrest,		Approxir Interval Onset a	Between nd Death
8760,		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, tossease or injury that initiated events resulting in death) Last	b. — Due to (or as a conse										
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d. 23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fei 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pro						23d. Date of Month	delivery Day	Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions con Atrial Fibrilla tide		sulting in the u	nderlying ca	use give	n in Part I.					e to the cause of	
Division of Vital Records,		Completed										prior deatl		gs available of cause of
<u> </u>	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2	 ⊒ ER/Outpatien	it 3 DO	Othe			n <i>(Check only</i> me 5□ Res		C 0015 //	200	
ion of	Jing Ph J. After th funeral	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work	463 1401	- 1	28d. Describe			ъресну)	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)	eet, factory	, office			28f. Location City or To			Rural Route N	lumber,
	Hosp 24 hou Fune stely fil	edical	29a. Certifier 1. Certifying Phy: (Check only one) 2 Medical Exami	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a th occurr	and due to the ed at the time,	cause(s , date an) and manner d place, and	r as stated. due to the caus	e(s)
	To the within To the comple	Mec	29b. Signature and title of certifier			29c.	License	number			29d. Da	te signed (M	onth, Day, Year	r)
	*		I pron Hac	S M.E		(i)	001	61190	ì		FC	6, 28.	2005	
	18		30. Name and address of person who co	6565 Norm	om 23a) (Type, Charle	Print)	, Sv,	te 2	20	Touson	12	0 21	204	
	Sta Registr		31. Date filed (Month, Day, Year) MAR (1 1 2)	OZ. I Maistral a Orgi	nature	bark	p							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 24, **FRIEDMAN** 2005 6:33 SIDNEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV.24,1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number **Funeral** 1 M 2 □ F Days Yrs. PA 78 182-20-8653 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County tems 23a or 28e-f show 1 ☐ Yes 2 ☐ No HARFORD ABERDEEN Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 602 ROWE DRIVE USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ▼ No WHITE 3 Widowed 4 Divorced "natural". 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) markad other than Elementary/Secondary (0-1 College (1-4or 5+) GROCERY STORE PROPRIETOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be ind Mental FRIEDMAN **GERTRUDE** PEARLMAN RUBIN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 602 ROWE DRIVE - ABERDEEN, MD 21001 ADELE FRIEDMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State HARFORD JEWISH CENTER 2/27/2005 ROSEDALE, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2500 24a. Was an 1 ☐ Yes V No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 🗌 Yes 20 No 2 ER/Outpatient 3 DOA 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Date of Injury Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28I. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of entifier

State

30. Name and address of person yoo completed cause of death (Item, 23a) Type, Print

31. Date filed (Month, Day, Year)

MAR 0 1 2005

32. Registrar's Signatur

nendolyn

- State Registrar

GWENDOLYN

5. Social Security Number

118-20-6158 Usual Residence of Decedent

10e. Street and Number

10a. State

Physician

/Medical

Examiner

Director

à

Funeral

Director

death with the Maryland

Decedent's Name (First Middle Last)

GRANT

6. Sex

PRINCE GEORGES

15. Decedent's Education (Specify only highest grade completed)

1 M 20XF

93

If Yes, Give Year or Dates:

College (1-4or 5+)

4a. Facility Name (If not institution, give street and number)

10b. County

1003 GREENBELT RD.# 201

Korge

MAR 01

31. Date filed (Month, Day, Year)

1 Never Married 2 Married

3 ₩ Widowed 4 Divorced

Elementary/Secondary (0-12)

DOCTORS COMMUNITY HOSPITAL

item 27 is marked other then "neture!", or Items 23e or 28a-f show other treumatic event, the Nedical Examinar must be notified at permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "any injury or other treumatic event, the Nation 2008. 17. Father's Name (First, Middle, Last) BROWN EMMITT ISADORA HALL 19a. Informant's Name/Relationship (Type, Print) JOAN L. GRANT-ARGUETA/DAUGHTER 1003 GREENBELT RD. # 201 LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FERNCLIFF CEMETERY 3/5/05 21. Signature of Funeral Service Eigensee 1000ao ema (23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart all re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ELEBROVASYLAR **Physician** /Medical **Examiner** CYKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit NZUMONIA Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the 050 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 20 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending hours after death. unerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of ca 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type Md. 20706 - 3596 8118 Good Lugh vanham

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ZUUD 3. Time of Death Month Day Year Phruary 25, 2005 12:35 AM 4c. County of Death 4b. City, Town, or Location of Death LANHAM PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Yrs. FEBRUARY 7.1912 VIRGINIA 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No LANHAM 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No BLACK Specify: Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CITY WORKER NEW YORK CITY 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State NEW YORK 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING RD. LAUREL, MD 20707 Approximate Interval Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 20 No 26. Place of Death Check onl one Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar gistrar's Signature

32.

2005

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	State of Man	yland / Dep	artment of	Health and	Mental Hy	aiene

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	Physic	ian	1. Decedent's Name	(First, Middle, La:	st)						2. [Date of Death	200	J	3. Time of Death
	/Med	ical		GARCIA-P								bruary	14, 200	55	3:00 P M
4	Exami	ner	4a. Facility Name (If n)				Location of I	Death		4c. County of [Death	
	Funeral		5. Social Security Nur	oan Hosp		ge (In yrs. las	t birthday)	Beth If Under	nesda 1 Year	If Under 24	Hrs. e F	ate of Birth	Montg	ome	ry
	Director		N/A		∏M 2□F	30	Yrs.		Days		Min. (/	Month Day, Y Oril 23	ear)	Countr	ice (State or Foreign y) tamela
	p ,		Usual Residence of D										7 137		- California
	anyla shov	2		10b. County		10c. City,	Town or Lo	cation						100	d. Inside City Limits
	the Ma 28a-f	ecto	MD 10e. Street and Numb		George's	Bel	tsvil								1 ☐ Yes 2 ☐ No
	with Sa or	급	4708 Naple		Δ			10f. Zip (10g	Citizen of Wha		y?
	death ms 23	Funeral Director	11. Marital Status	- Avenu	12. Was Decedent	Ever in U.S.	13 \		0705	nanic Origin	2 (Specify)	Vas or No-	Guatema:		a ladian
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. I have seen seen seen seen seen seen seen se	þ	1 XX ever Married 3 □ Widowed 4		Armed Forces: 1 ☐ Yes 2 ★ If Yes, Give Year or Dates:	?		Yes, speci		spanic Origin , Mexican, F Specify:	Guatem		Black, V Specify:	Vhite, et Whit	c.
5-0	72 ho natu	eted	1. (Specify	5. Decedent's Ec	lucation de completed)		16a. Deced	lent's Usual	Occupat	tion	f working	16	b. Kind of Busine		
21215-0036	2 should be filed within and Mental Hyglene. Is marked other than " eumatic event, Ina Me	Completed	Elementary/Second Grade 6		College (1-4or	5+)		abore:		iring most of	i working		anitatio ecycling	,	
ind	be fill ttal H d off	Be	17. Father's Name (Fi										iden Sumame)		
Maryland	should ind Meni	2	Faustino G								elay P				
Ma	d 2 s lth an 27 Is I	1 8	Marina Lem	. , ,	friend					nd Number o Venue			city or Town, State Maryla		20705
ore,	permit. Pages 1 and. Department of Health Important: If item 27 eny injury or other tr once.		20a. Method of Dispos	sition	Removal from State	20b. Plac		sition (Name			Date		c. Location - City		
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		`4 □ Donation 5	Other (Specify	')		nteri	o Juti	iapa	Ma	rch 8	2005 J	utiapa,	Gua	temala
Ba	permit. Departr Imports eny inju		21. Signature of Fune	San		/ M007	770	31.	3 Ta.	Lbott	Avenu		rel, Mar	ryla	nd 20707
			23a. Part 1. Enter the shock, or heart f		plications that caused one cause on each li	d the death. I	Do not ente	er the mode	of dying,	such as car	rdiac or resp	piratory arrest		lr.	pproximate iterval Between
	Physician /Medical		Immediate Cause (Fir disease or condition resulting in death)	nal	a/	Multiple		June	Ś						nset and Death
	Examiner		,	- (Due to (or as	a consequen	ice of):	J							
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	cuted nd ransit	Examiner	Cause (Disease or injustration in that initiated events	ing ury	C										
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	eath certific attending p for use as		IF FEMALE:		23c. If yes, outcome	of pregnance									=
Вох	atten atten I for u	Physiclan/M	23b. Was decedent print the past 12 mg	onths?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3	Ectopic pred					23d. Date of a Month	delivery Da	ay Year
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σ,	es that igned b	by P	Part II. Other significa	int conditions co	ntributing to death b	ut not resultin	g in the un	derlying cau	ıse given	in Part I.	2	3e. Did tobac	co use contribute	to the	cause of death?
ıd	w require been sig should b										_	1 Tes	2 No 3	Probabl	ly 4 Unknown
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H		Com									_	autopsy performed Yes 2	l? death	o compl ? es 2	letion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred examiner?	-	I to enite li	77		_	1	6. Place of I	-	ck only one)			
of	8 W =	2	1 Yes 2 No 27. Manner of Death		Hospital: 1 ☐ Inpatie 28a. Date of Inju		Outpatient	3□ DOA			ng Home 5	Residence	6 □Other (S	pecivi)	
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Division	I or Attending after death. Director: After I in by the fune	flca		6 Could not be	2/14/05 28e. Place of Inju	ırv - At home	:34 /	et. factory		s - M					
ă	itel or firs after rel Dire	Certification;	4 Homicide	dotominod	building, etc	c. (Specify)	reet	-, -=,			Bethe	ty or Town, Si	tate) St. Paul S	st +1	oute Number, McComas Ave
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	rsician: To the best of iner: On the basis of and manner sta	examination	dge, death and/or inve	occurred at estigation, in	the time, my opin	date and plaining date and plaining death of	ace, and du ccurred at ti	e to the cause he time, date	e(s) and manner and place, and d	as state	d. e cause(s)
	To the within 2 To the complet	A Me	29b. Signature and title	e of certifier	11			29c. L	_icense n			29d.	Date signed (Mo	nth, Day	r, Year)
(turne	hy but	MU MD	-				_		Fe	bruary	16.	2005
_ '	6		30. Name and address	la E. S	withall, mD			111	Pen	n Stre	eet F		ore, Mar	13	
	Sta Registr	te ar	31. Date filed (Month,)	Day, Year)	32. A gistra	ar's Signature	· A	ale .						,	and the first Of the

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Joanna Marie Gabriel February 2005 09:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital N/ABaltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 48 Yrs. 299-62-4738 Kansas Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Medical Examinant the notified at 1 ☐ Yes 2 No Director Inkerman Luzerne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 18640 USA 292 Heather Highlands Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VA Medical Center EKG Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martha Ellen Clark Kenneth Leroy Karns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 292 Heather Highlands Inkerman, PA 18640 Theodore D. Gabriel, Sr./Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 cemetery, crematory or other place)
Cremation Society 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 2/28/05 Harrisburg, PA `4 ☐ Donation 5 ☐ Other (Specify) of Pennsylvania 21. Signature of Funeral Service Licensee ²²Aver Memorial Home & Cremation Services, Inc. Edward A. Gregorchik 4100 Jonestown Road Harrisburg, PA 17109 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Aterios denti Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ llitu 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXYes 2 □ No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a OCME February 24, 2005 who completed cadse of death (Item 23a) (Type, Print) Kon 111 Penn Street Baltimore, Maryland 21201 MC 32- Registrar's Signature 31. Date filed (Month, Day, Year) **State**

DHMH 17 Rev 1/2001

Registrar

MAR 0 1

2005

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 25, 2005 **Physician** February William E. Gooding 7:36 PM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X** M 2 ☐ F Yrs. 219-34-8454 December 19, 1937 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked othar than "natural", or ftems 23s or 28a-1 shov any injury or other traumatic avant, If it is Marifical Examinating the resulties at 1 Yes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 529 Carr Avenue 20850 Montgomery 12. Was Decedent Ever in U.S. Armed Forces?

1 △Yes 2 □ No 195 If Yes, Give Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1958 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 1961 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense 12 Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Marshall Gooding Dorothy Marie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Maria C. Gooding/ Wife 529 Carr Avenue, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Crematorium, inc. March 1, 2005 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licenses M01405 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Liver Failure /Medical Due to (or as a consequence of): **Examiner** Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Sepsis and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 🗌 Yes 2X No 1 Yes 25. Was case referred to medical examiner? Physiclan: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 25 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? at or Attanding P after death. I Director: After t Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To tha Funaral Di Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25-05 1)005489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Charles, M.D. 15005 Shady Grove Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

05 - 1394B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PETER P. HAYES Amend Item 1&Unpend Item 23a,27,28a-f per me G841 3-14-05 certificate of Death tas Reg. No. Reg. No. U tas Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year FEB. 20 2005 /Medical 4b. City, Town, or Location of Death BALTIMORE CITY ame (If not institution, give street and number MADISON AVENUE APT. 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex Birthplace (State or Foreign Scriptly)

Ward and Days 1 M 2 F Months Hours Min 214-62-6798 Usual Residence of Decedent Yrs. Director Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show must be nulliked at Completed by Funeral Director 1 Nes 2 No more filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ items 23e 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Çuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 1 Yes 2 No 14. Pace - American Indian, 11. Marital Status in U.S other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced 100 'natural' 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NQT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ges 1 and 2 should be filed withir t of Health and Mental Hygiene. If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Haye 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date MO 28 20a. Method of Disposition 20c. Locati - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) rinitu Cemeteru 0 2. Name and Address & Facility 21. Signature of Funeral Service Licensee Home 713gh eneral Balto MU AVL North 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Frysician Immediate Cause (, disease or condition resulting in death) Narcotic intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2/XI No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE 2 1 XYes 2 ☐ No 28b. Time of **unk** 28c. Injury at Work? 28a. Date of Injury Found to, Day Year) 2-20-05 27. Manner of Death Certification: 28d. Describe how injury occurred unk After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and North of Mad Ison Ave. in by 4 - Homicide Home

after death Director:

within 24 hours a To the Funerel L ٥

29a. Certifier

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Medical

State

29b. Signature and

2005

Baltimore, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: то the best of my кложебуе, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ag

111 Penn Street

OCME

FEB. 24, 2005

Baltimore, Maryland 21201

Registrar

registrar's Signatur

			1 - For State Registrar	State of	Marylar	nd / Depa	artment rtificate			and M	lental H	ygier Reg. i		5	06655
	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of D	eath	Day	Year	3. Time of Death
	/Media		Naomi J. Hartzel								Feb.		2005		3:00 A M
	Examin	er	4a. Facility Name (If not institution, given 1359 Jamestown D		ber)		4b. City, T Seve		Location o	f Death		'	4c. County		. J . 1
	- Consol				. Age (In vrs	last birthday)	If Under 1		If Under 2	24 Hrs. T	8 Date of B	irth		Arur	
	Funeral Director			1□M 2ÅF	74	Yrs.		Days	Hours	Min.	8. Date of B (Month, L June	Day, Yea	930	Mary	place (State or Foreign http:// Land
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limits
	Mar Miled	ctor	Maryland Anne Ar	unde1	S	evern									1 ☐ Yes 2 🛣 No
	iff th	Jire	10e. Street and Number				10f. Zip (10g. (Citizen of \	What Cour	itry?
	ath w	ral	1359 Jamestown D				211	44				Uni	ited	State	S
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "naturel", or Items 23a or 28e-1 show eny injury or other treumetic event, the Medical Evantinal must be notified at ODDE.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	es? 2 🔯 No		Was Decede f Yes, specif 1 ☐ Yes 21	fy Cubai	spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto I	cify Yes or N Rican, etc.)	lo-		e - Amend ck, White, '' Whi	etc.
9	2 hou	ted	15. Decedent's E			16a. Deced	dent's Usual	Occupa	ation			16b.	Kind of Bu		
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Ind	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Las	,							(First, Middle			ie)	
<u>}</u>	Men Men Marke Metic	T _o	William F. Bruch	2							th Mit				
Mai	12 sh h and 7 le n treun		19a. Informant's Name/Relationship Stacey Merritt/								l Route Numi				Code)
e,	1 and Healt em 2: ther		20a. Method of Disposition	Daugnter	20b. F	lace of Dispo	the latest		ive.,	-	adena,	-	211		Chat-
Baltimore,	ages nt of t: If it		1 Burial 2 □ Cremation 3	Removal from S	tate	emetery, cren	natory or oth	er place		Ma	ar. 2		Location -		
턡	artme orten injury		 4 □ Donation 5 □ Other (Spec. 21. Signal up of Funeral Service Lice 		01	rownsvi					2005				, Maryland
Ba	permi Depa Impo eny it		1/4/2/2			Ki 42	rkley l Cra	-Ruc in I	ldičk lwy.,	Fune S.E.	eral H	ome, n Bu	P.A rnie	, MD	21061
	Pnysician /Medical Examiner	J.	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Seguentially list conditions, if you lead to immediate.	a Due to (o	r as a conseq	CAV uence of):	CTC		, such as c	ardiac of	r respiratory a	arrest,		P	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Lissaes of it fur) that initiated events resulting in death) Last	c	r as a conseq										
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rds, P	es ti	by	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the un	derlying cau	ıse givei	n in Part I.						e cause of death?
Vital Record	The law resate has be page 2 sho	Completed										psy ormed?	d d	rior to com eath?	psy findings available appletion of cause of
ital		Bec	25. Was case referred to medical						26. Place of	of Death	1 ☐ Yes (Check only		0 1	☐ Yes	2□ No
	S S S	2	examiner? 1 ☐ Yes 2 🎛 No	Hospital: 1 Ing	oatient 2	ER/Outpatient	3□ DOA	Othor			e 5 🗷 Res		6 Othe	r (Specify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	280	. Injury			8d. Describe				
sio	r Attending er death. rector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2□N	- 1					
Division	or Attencafter death Director: in by the	Certification:	4 Homicide determined	28e. Place o	f Injury - At ho I, etc. <i>(Specif</i>)	me, farm, stre	et, factory, o	office		2	8f. Location (City or To	Street a	ind Numbe te)	or or Rural	Route Number,
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	he H n 24 he F	Medical	one) 2 Medical Exa	nysician: To the b miner: On the bas and manne	is of examina	wieage, death tion and/or inv	estigation, in	n my opi	nion, death	place, ar	nd due to the d at the time,	date ar	nd place, a	nd due to	the cause(s)
	To Too	1	29b. Signature and title of certifier	11. 4	A 43		29c. L	License					ate signed		
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0) (3001 Hanover St.	, Baltimo	re, MD	21230									
	Stat Registra	ie ar	31. Date filed (Month, Cay Year) 2(05 32 deg	istrar's Signa	ture	ويمكون								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 25, 2005 Juanita G. Huffman 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1405 Rowe Drive Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Ye **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Year 215-28-9358 Director 76 Maryland 1929 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic evant, the Medical Examiner rust be notified at Maryland Anne Arundel Glen Burnie Director 1 TYes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a 1405 Rowe Dr. 21061 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural', or Iten any injury or other traumatic evant, I're Medical Exa pling. once. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No ۵ Specify: 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounts Clerk Retail Sales 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Anthony George Jacober Pauline A. Pohlman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph B. Huffman / Husband 1405 Rowe Dr., Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State March 2. * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2005 Catonsville, Maryland 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, MD 21061 21. Signature of Funder I Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Carlis Vinnelan Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Champia Obstructive Plumpnary Myeuse 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à page 2 should Be Completed 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2⊠ No 2□ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🔀 No his 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier ٥ 29c. License number 29d. Date signed (Month, Day, Year) 100 23 811 muin mu February 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1406-B Crain Hwy., S, Glen Burnie, Maryland 21061 Johothan Forman, M.D., 31. Date filed (Month, Day, Year) Registrar's Signature MAR 0 1 2005 Registrar

	•	Please State Registrar	Type or Print in State of Maryla	and / Depa		ealth and N	Mental Hyg	_	06657
Physicia /Medic	_	1. Decedent's Name (First, Middle, La	st) es A. Hanna				2. Date of Dea Month February	Day Year	
Examin Funeral Director			E Lane Gex 7. Age (in year)	rs. last birthday) 45 Yrs.	4b. City, Town, or ESS If Under 1 Year Months Days	Sex If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year) C	
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with the Mar a or 28e-f s	Director	10e. Street and Number	imore		Essex 10f. Zip Code 2122	0.1		10g. Citizen of What C	1 □ Yes 2 ₩ No ountry?
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be filed within 72 ho ital Hygiene. Id other than "naturi event, Ital Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired OCiate	ation during most of world)	king	16b. Kind of Business Wal-Mar	,
nuid be filed Mental Hyg srked othe	To Be C	17. Father's Name (First, Middle, Las Austin D. Ha				Elle	en R. L		
1 end Health tem 27	9	19a. Informant's Name/Relationship Mary E. Morri: 20a. Method of Disposition	s /sister	22		eyer Hol		or, City or Town, State, ad Stewa: 20c. Location - City or	rtstown PA
permit. Peges Depertment of Importent: If it any injury or o		M☐ Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	fy)	HollyH	illCemet 2. Name and Addre	ss of Facility Co	onnelly		omeofEssex
Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List ent Immediate Cause (Final disease or condition resulting in death)	a. A levioscle Due to (or as a cons	notic (g, such as cardiac	or respiratory ari		Approximate Interval Between Onset and Death 5 y Lan S
Examiner sicten and purial-transit	al Examiner	Sequentially flat currents, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
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pital or Attendi burs efter death, erel Director: A	O	4 ☐ Homicide determine	28e. Place of Injury - A building, etc. (Sp	ecify)		me date and place	City or Tow	m, State)	
To the Hoepital or Attending Within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune	Medical	(Check only one) 2 Medical Extends one) 29b. Signature and the of certifier	aminer: On the basis of exam and manner stated.	nination and/or in	nvestigation, in my c	pinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
Ϋ́	2	30. Name and address of person wh	o completed cause of de th (Item 23) (Type	Print)	3667		February	
Sta Regist		Philip Militello 31. Date filed (Month, Day, Year)	32. Regionar's S	ble Hill ignature	CT. Lut	vav n:116	Mary la	ind 210°	13
DHMH 17 Rev 1/2		MAK U I	2005 Store	1 10.	man				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** EUGENE HOWARD, JR. 10:32 p M RALPH February 23, 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1√2 M 2 □ F 497-52-9185 56 Feb 20, Missouri Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating rules be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No XX Director Anne Arundel Laurel 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 8368 Brock Bridge Road 20724 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₩ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Grade 12 Operations Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Eugene Howard Dorothy Wunning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana Howard 8368 Brock Bridge Road Laurel, Maryland 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3XX Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Francis Mem Park 3/2/2005 Park Hills, MO 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Amyotrophic Lateral Sclerosis year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the buriat-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 DEctopic pregnancy Day Month Year ţōţ in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2XXNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes XXNo 1 Tes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XXo 2XXER/Outpatient 3 DOA Medical Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After ! 1 X Matural 5 Pending after death. 1 🗌 Yes 2 🗌 No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Momicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Inde fleulions D 0036716 Feb. 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D. 8317 Cherry Lane Laurel, Maryland 20707 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State MAR 01 2005 Registrar

			For State Registrar	State of	Maryland /	Depa		t of H	ealth a		lental Hyg		005	1 116	659
	0		Decedent's Name (First, Mi	iddle, Last)							2. Date of Dea	ıth			of Death
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	/Medic Examin		4a. Facility Name (If not institu					Town, or	Location of	of Death			ounty of De		
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	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. last b	irthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	h (Voar)		irthplace (State Country)	e or Foreign
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ğ	il Hygie other	a)	17. Father's Name (First, Midd	dle, Last)					18. Mothe	er's Nam	e (First, Middle,	Maiden S	umame)		
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a J	2 should and Men Is marke aumatic		19a. Informant's Name/Relati	onship (Type, Print)	19	b. Mailin	g Address	(Street a	nd Numbe	or Aur	al Route Numbe	r, City or	Town, State,	Zip Code)	
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Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 lt any injury or other tra gnce.		21. Signature of Fundral Serv	rice hirensee	4-	22	. Name an Lemmo	d Addres	s of Facilit	Y I Ho	me of Du	ılane	v Val	lev Inc	c.
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THE PERSON	Physician /Medical Examiner	ė.	23a. Part1. Enter the disease shoot or heart ailure. Immediat Cause (F al disease or ondition resulting in death of the conditions, if any, leading to immediate	aDue to (o	r as a consequence	of):	e in mon	o or dying	g, 9001 as	cardiac	or respiratory an	iest,		Approxim Interval E Onset an	Between
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000	aw renas bee	Completed									24a. Was		24b. Were a	autopsy finding	s available
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0	g Physter this	n; T	27. Manner of Dear	28a. Date of	Injury 28b.	Time of Injury	2	8c. Injury Work	at ?		28d. Describe h	ow injury	occurred		
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Division of Vi	pital or Attending F

		1	For State	State of Maryla		artment of H rtificate of I			giene Rag. No?	105	06660
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with	3£ of	Funeral Director	5711 Forest R	oad		2.0	785		US	Α	
death	ms 2	nerg	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	
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- an	Heal tem 2 other		20a. Method of Disposition	20	b. Place of Dispo			Date	_	ion - City or To	
	ant of nt: If I		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State			Inc. 2/2	7/05	Po l	tinore	MD
SAITIMO Darmit. Pages	oartm sortar / inju	1	21. Signature of Funeral Service Lice	ensee / «	2	2. Name and Addre	ss of Facility			Leslet B.Z.L. Va	• 1,1-2
ă ă	Depar Impor any ir		Edward A. Gre	gorchik	2	99 Freder	Society o	Baltimo	ore, M	D 21228	3
			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caused the d y one cause on each line.	eath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	rysician	6 0	Immediate Cause (Final disease or condition	a pneumor	nia						onsor and boats
	Medical kaminer		resulting in death)	Due to (or as a con	sequence of):						
		i i	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):						
petr	ansif	i i	cause. Enter Underlying Cause (Disease or injury that initiated events								
о жес	an and rial-tra	Examin	resulting in death) Last	Due to (or as a con	sequence of):						
8 / 5U , icate be executed	physician and s the burial-transif	ical	•	d							
	ing ph e as t	Medi	IF FEMALE:	00 - 16					-		
Geath certif	attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time	etal death 3	□Ectopic pregnancy □ Other (specify)	4		230	I. Date of delive Month	Day Year
် နီ	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	or death 5t						
J	igned by be deta		Part II. Other significant conditions	contributing to death but not	resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did 1	obacco use	contribute to the	ne cause of death?
Hecords,	n sigr	ed by	Dementia					1 🗆	Yes 2K	lo 3□Prob	ably 4 Dunknown
eco law re		Completed						24a. Was		24b. Were auto	psy findings available impletion of cause of
	- B	mo							rmed?	death? 1 ☐ Yes	
Vital sician: 1	certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
Of Vita	this ce	2	1 ☐ Yes 2 🛣 No		2 ER/Outpatie		4 Nuising m	ome 5 Resi			y)
	Afte	Certification:	27, Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Wo	ryat rk? Yes 2 □ No	28d. Describe	now injury o	ccurred	
JIVISION or Attending	death.	icat	2 Accident investigat 3 Suicide 6 Could not	be age Place of Injury	At home, farm, st					lumber or Rura	I Route Number,
DIVISION I or Attending	after death Director: /	ertil	4 Homicide determine	building, etc. (Sp		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)		
Hospita	within 24 hours aft To the Funaral D complefely filled in	Medical C		Physician: To the best of my aminer: On the basis of exar and manner stated.							
o the	o the	Mec	29b. Signature and title of certifier	0		29c. Licens	se number		29d. Date s	igned (Month,	Day, Year)
Ĺ	≥ ⊢ ŏ			S. Sidh		D4	12014		Febri	ary 2	5, 2005
	IXA		30. Name and address of person wh	o completed cause of death	(Item 23a) (Type	Print)					
-	17		Surinderpal S	odhi, M.D., V.	A Mary	land Hea	alth Car	e Syst	em, Pe	erry P	oint,MD
		ate	Surinderpal So 31. Date filed (Month, Day, Year) MAR 0 1	32. Repstrar's S	ignature /	Sparke					
DUM	Regist	rali	MAK 0 1	2003	/	-					

State of Maryland / Department of Health and Mental Hygiene 0.05For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 20, 2005 **Physician** 11:50 A.M P. Holt Marvin Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arnold Anne Arundel 1425 Gilbert Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** M 2□F 77 Kentucky 401 36 8412 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "netural", or Items 23s or 28e-f show 1 ☐ Yes 2√2 No Maryland Anne Arundel Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 21225 409 Waverly Avenue ould be filed within 72 hours after death. Mental Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc ☐Yes 2MNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 □ Divorced Year or Dates: White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) 2 years American Can Company Machinist other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marvin P. Holt Sr. Bertha E. Thomas Pages 1 and 2 should nent of Health and Men 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arnold, Maryland 21012 Health tem 27 Marvin Holt III / Son 1425 Gilbert Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/2005 Baltimore, Maryland Cedar Hill Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 rapellall Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** and O 00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: esu. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed3 2 / No certificate 2 No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 05 istrar's Signature State 2005 Registrar

amend item#1, Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Ella Louise Heckner 1. Decedent's Name (First, Middle, Last) 3:00PM **Physician** 2005 FEBRUIARY /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAMBRITAN 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖸 F Director 217-18-1524 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show r then "natural", or Itams 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2√ No Funeral Director Maryland | Harford Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7301 Temple Lane 21087 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2XNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home Homemaker . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 le marked other ti jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cassandra Marie Harkins George Heuisler Poole ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7301 Temple Lane, Kingsville, Maryland 21087 George Emil Heckner Jr.-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages I Department of I Important: If ite eny injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2/21/05 Towson, Maryland Hilltop Corporation 4 □ Donation 5 □ Other (Specify)
21. Synthy of Fyleral Service Licence 22. Name and Address of Facility
McComas Funeral Home 1317 Cokesbury Road, Abingdon, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit and Due to (or as a consequence of) the attending physician hed for use as the buria IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown à been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No certificate 1 Yes 2 NO 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 € No 1 Inpatient 2 ER/Outpatient 3□ DOA 7 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After Injury 5 Pending 1 Matural 1 🗌 Yes 2 🗌 No after death.

Director: Af investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Thomicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital or Attanding Physician:

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

terifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name COCHPONEN BUD. 1.0-HERBEF 5601 32.

State Registrar

29a. Certifier

Year) 31. Date filed (Month

bistrar's Signature

within 24 hours a

			FOF	of Maryland / Dep			fental Hygi	ene	00000
			State Registrar	<i>C</i> e	ertificate of	Death	2. Date of Death	g. No UUU	00000
	Physicia	an	1. Decedent's Name (First, Middle, Last) MAD CARET, CHE, HETLAND				Month	Day Year	3. Time of Death 1:25 A M
	/Medic	al	MARGARET SUE HEILAND 4a. Facility Name (If not institution, give street and	number)	4h City Town	or Location of Death	02	23 2005 4c. County of Dea	
ı	Examin	er	FUTURE CARE CHESAPEAK		ARNOLD	of Cooking to Docum		ANNE ARU	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
п	Director		220 - 01 - 6352 1□ M 2□X	85 Yrs.	Months Days	Hours Min.	8/26/19	19	MD MD
	D ≥		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	sho	5	MD ANNE ARUNDEL	PASADENA					1 ☐ Yes 2 🛣No
	28a-i	Director	10e. Street and Number	THORDEN	10f. Zip Code		10	g. Citizen of What C	ountry?
	3a or		P.O. BOX 1444		21123	3		USA	
	death	Funerai	11 Marital Status 12, Was D	Decedent Ever in U.S. 13 1 Forces?	3. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whi	
9	after or Ite	/Fu	1 Never Married 2 Married 1 Yes	es 2 No Give X	1 ☐ Yes 2 No				HITE
Š	urali,	d by	3 N Widowed 4 Divorced Year	or Dates:	cedent's Usual Occur	nation	1.	6b. Kind of Business	/Industry
15-	n 72 "nat	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Gi	ve kind of work done . DO NOT use retire	during most of work		ob. Killa of Dasiness	vindustry
12	withliene.	шо	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	MEMAKER			OWN HOM	Ε
D	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene and the "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show awent. Its Madical Examination in the notified at	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, M.	aiden Sumame)	
<u>lar</u>	should by and Menta markad	To E	UNKNOWN			UNKNOW			
Maryland 21215-0036	0 20 0	Ì	19a. Informant's Name/Relationship (Type, Print)					City or Town, State,	Zip Code)
	of Health Item 27 other tr		MR. WESLEY HEILAND / S 20a. Method of Disposition		BOX 1444			1123 0c. Location - City or	Town State
altimore,	Pages I nent of H ant: If Ite ary or ot		1X Burial 2 ☐ Cremation 3 ☐ Removal fr	om State cemetery, c	rematory or other pla	ice)		,	
<u>=</u>	교원분들 .		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 	MD VEIER	22. Name and Addre			CROWNSVILI FUNERAL HO	
Ba	permi Depa Impo any is		MICHIEL Coone	MO1415		AVE., SW,			21061
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause						Approximate Interval Between
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):					
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89									
ŏ	th cer endin	an/N	23b. was decedent pregnant	outcome of pregnancy ve birth 2 Fetal death	3 □Ectopic pregnanc	су		23d. Date of de Month	blivery Day Year
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as if	Physician/Med		regnant at time of death nknown	5 Other (specify)			INCONT	Day Tour
<u>Ч</u>	d by t	Phy	Part II. Other significant conditions contributing	to death but not resulting in the	a underlying cause g	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
	signe d be d		A / //	weare	, and any mg area o g		1 ☐ Yes	A	robably 4 Unknown
Vital Records,	w requir been si should	Completed by	0				24a. Was an	24b. Were a	utopsy findings available
Rec	eician: The law certificate has E irector, page 2 s	dui					autopsy perform	ed? prior to death?	completion of cause of
a	ificate or, pa	e C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 th (Check only one	2(No) 1 Ye.	s 2 No
>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpat	tient 3 DOA Ot	hon Na		nce 6 Other (Spe	ecify)
o c			27. Manner of Death 1 Natural 5 ☐ Pending	ate of Injury 28b. Time Month, Day Year) Injur		ork?	28d. Describe how	w injury occurred	
<u>S</u>	uttendir death. ctor: Al y the fu	catic	2 Accident investigation]Yes 2□No	001 1 11 101		
Division	or Att	ertification:	determined 280. F	lace of Injury - At home, farm, uilding, etc. (Specify)	street, factory, office	1	City or Town,	eet and Number or F State)	surai Houte Number,
	pitel	O	29a. Certifier 1 Certifying Physicien: To	the best of my knowledge, de	eath occurred at the t	ime, date and place	and due to the car	use(s) and manner a	s stated.
	24 hc 24 hc e Fun etely	edical	(Check only 2 Medicel Exeminer: On to	ne basis of examination and/or manner stated.	r investigation, in my	opinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: Afte completely filled in by the fune	Me	29b. Signature and title of certifier	^	_	ise number		d. Date signed (Mon	
	•		My Alle	Ending Doctor	1 0	21684	1	02-23	-2005
	1)		30. Name and address of person who completed					MD 211	
			C.V. CYRIAC M.D	8021 RI	ICH UNY	INAJAC	IENT,	170 211	22
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 1 2005	22. Registrar's Signature	de				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 27, 2005 4:50 P Bruce Healy February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson
If Under 1 Year Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 27,1930 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 11XM 2□F Months Hours Min 217-24-9659 74 Maryland Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Gateswood Road 21093 U.S.A. 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after deeth ment of Health and Mental Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 MYes 2 □ No If Yes, Give 1953-1955 Year or Dates! Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 X Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Vice President Rendering Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be marked Healy Gau 2 Kenneth James Laura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 1219 Brook Hollow Road Towson, Maryland <u>Michael B. Healy</u> 21286 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Importent: if it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 3-4-2005 Parkwood Cemetery Parkville 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Montas **Physician** -UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-transit resulting in death) Last Due to (or as a consequence of): physician Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. vision of Vital Records, þ 2 X No 1 Tyes 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificete has b autopsy 2 1 No 1 ☐ Yes 25. Was case referred to medical 26 Place of Death (Check only one) director Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence ther (Specify) Weisp uce ٩ 1 ☐ Yes 2 No this After the funeral 27. Manner of eath
Natural
Decident 28c. Injury at Work? 28d. Describe how injuly occurred 28b. Time of Certification: Hospitai or Attending Injury 5 Pending 2 🗌 No investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C 29a, Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) N (Month, Day, Year) State

Registrar

naine Jac	ks	Item#8,per FH,G84 In State Registrar	1,540140	on de la composition della com		cate of		rivicritarri	Reg. No.	105	06665
٥		1. Decedent's Name (First, Middle,		4	,			2. Date of I		Vone	3. Time of Death
Physic /Medi				Jack				Febr	uary 10		00:44 AM
Exami	ner	4a. Facility Name (If not institution,		mber)			r Location of De	ath	4c. Cou	nty of Death	1/1
Europol		University Hospi 5. Social Security Number 6	. Sex	7. Age (In yrs. last t		altimor Under 1 Year	CE If Under 24 H	rs. 8. Date of E	3irt12/16/	849. Birthr	place (State or Foreign
Funeral Director		215-08-0654	1 □ M 2□F	20	Yrs. Mo	nths Days	Hours Mi		Day, Year)	Cour	place (State or Foreign htry)
pu »		Usual Residence of Decedent 10a. State 10b. County		10a Ciby Ta							
farylan show	a	MD N	/h	10c. City, 10	wn or Locatio					,	10d. Inside City Limits 1 Yes 2 No
:1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f show re Medical Examiner must be notified at	Director	10e. Street and Number	/ //	E		ore Ore			10g. Citizen	of What Cour	
3a or	D	4140 Fie	rman	Ayen	ue		21206			125	10
r death v ams 23a ar must	Funeral	11. Marital Status		edent Everin U.S.				(Specify Yes or lento Rican, etc.)	No- 14. F	Race - Americ	
36 saffer	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, Gi	2 ∰No ve		es 20 No	Specify:	ono riioan, oto.)	Spe	1	91C.
hours tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or E		a Decedent's	Heural Occurs	ation			0	rack
15. In 72	Completed	(Specify only highest	grade completed)		(Give kind life. DO N	Usual Occup of work done o OT use retired	during most of w	rorking	16b. Kind of	Business/In	dustry
d 212 filed within Hygiene. other than ant, Ire M	mo:	Elementary/Secondary (0-12)	College (1-40r 5+)		tude			Hie	ih Sc	hoo/
aryland 2. should be filed v nd Mental Hygie i markad other t umatic avant, II	Be (17. Father's Name (First, Middle, La	st)				18. Mother's N	ame (First, Midd	-		-
ylan outd be Mental Markad c	2	Bernard	mye	rs					Tacks		
C 6 5 6		19a. Informant's Name/Relationship	Thomas	1 11	9b. Mailing Ad	n		Rural Route Nurr		41.5	
ire, N is 1 and of Health itam 27 other tr	1 3	20a. Method of Disposition	1 10 mas	20b. Place	of Disposition	(Name of	rman	AUEN	1	n - City or To	2 MD 21206
ages ant of little it it it		1 MBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State Cemet	-	or other place	(e)	17/05		formund	
Baltimo	1 8	21. Signature of Funeral Se vice Li		1/017.	22. Na	ne and Addres	se of Facility	1//03	15	+ ANTIC	PA
Depa Impo		1	-	_		Her	6 50	lain Ro	al Bul	timore	MOZIZOB
· ·		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that only one cause on e	caused the death. Do							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	guy!	shot Wa	ul 1	2) 1	Tw	16		_ 1	Onset and Death
/Medical- Examiner		resulting in death)	Due to	(or as a consequence	e of):	7	, , ,				
	<u>-</u>	Sequentially list conditions,	b	(or as a consequence	e off:						
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury									
be executed sician and burial-transit		that initiated events resulting in death) Last	c Due to	(or as a consequence	e of):						
ate be executed hysician and the burial-transi	dicai		d								
		IF FEMALE:	,					-	1		-
The law requires that the death certific: te has been signed by the attending pl page 2 should be detached for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	tcome of pregnancy birth 2 Fetal dear		oic pregnancy				Date of delive	ery Day Year
he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9☐ Unkn	nant at time of death own	5 ∐ Oth	er (specify)					
that the dended by the a	y Ph	Part II. Other significant condition	s contributing to d	eath but not resulting	in the underly	ing cause give	en in Part I.	23e. Dio	tobacco use co	ontribute to th	ne cause of death?
quires n sign ald be								1 🗆]Yes 2□No	3 🗆 Prob	abiy 4 Unknown
aw require as been sig 2 should b	ompleted							24a. We		o. Were auto	psy findings available
The lav	E O							per	opsy formed? 2 \(\subseteq \text{No} \)	prior to cor death? 1/13 Yes	mpletion of cause of 2□ No
ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only		103	20110
Attending Physician: r death. ector: After this certification the funeral director, I	은	1 XYes 2 No			Outpatient 3		- Linuising	Home 5□Re	sidence 6 🕱	ther (Specify	Scene
ding Ph h. After thi funeral	on:	27. Manner of Death 1 □ Natural 5 □ Pending		of Injury th, Day Year) 28b.	. Time of Injury	28c. Injun Work		28d. Describe	how injury occ	urred	
lor Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be d	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	he FILL		304 40	10'	Yes 2 No	July 1	not sh	- 7	10
spitel or Atten ours after deat larel Director: filled in by the	Certification;	4 Homicide determin	ed 200. Flace buildi	of Injury - At home, ing, etc. (Specify)	tarm, street, t	ictory, office		City or T	own, State)	(1) East	I Route Number,
Hospitel Hospitel Funaral I		29a. Certifier 1 Certifying	Physician: To the	best of my knowledg	ge, death occ	rred at the tim	ne, date and place	ee, and due to th	e cause(s) and	manner as st	ated
To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex	aminer: On the b	asis of examination a ner stated.	and/or investig	ation, in my o	pinion, death oc	curred at the time	, date and place	e, and due to	the cause(s)
To the To the Comple	Me	29b. Signature and title of certifier	/		**	29c. License			29d. Date sign	ned (Month, I	Day, Year)
n NI		Theoder	UX	Lund		0	CME		Februar	v 10.	2005
12		30. Name and address of person wi	o completed caus	of death (Item 23a) (Type, Print)	111 -	a .			Contraction of the	
/		THE ODGRE 1	1 Kang			III Per	nn Stree	et Balti	more. M	arylan	d 21201
	ate	31. Date filed (Month, Qay, Year)	1	leg rar's Signature							

			State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygi	_	5 06666
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Ye	3. Time of Death
	/Media		Lillie Moe Jackson		2 0	***	005 8 pm M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 1012 N. EDEN STREET	4b. City, Town, or Location of Death BALTIMORE			Death I/A
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth MARCH 12	^y ear)1928 N	Birthplace (State or Foreign Country CAROLINA
	yland		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	e-fst	ctor	MD N/A BALTIMORE				1 X Yes 2 ☐ No
	th with the 23s or 28 ist be no	Funeral Director	10e. Street and Number 1012 N. EDEN STREET	10f. Zip Code 21205		g. Citizen of What	t Country?
980	be filed within 72 hours after death with the Maryland nat Hygiene. Indoor than "natural", or Items 23a or 28e-1 show deent, the Modical Examinar must be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □WNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	pecify Yes or No- o Rican, etc.)	Black, V Specify:	American Indian, White, etc.
2-0	72 hor	ted	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	10	6b. Kind of Busine	BLACK ess/Industry
21215-0036	d within 7 giene. er then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired) KEEPER		RIVATE H	OME
Maryland	uld be filed Jental Hygie rked other tic event, I	To Be (17. Father's Name (First, Middle, Last) GRAHAM PARRISH	18. Mother's Nam. HALLIE MC	e (First, Middle, Ma CCAIN	aiden Sumame)	
lar)	2 should and Men Is marke eumatic	. 5		ng Address (Street and Number or Run			
	es 1 and 2 should of Health and Mer f item 27 Is marke r other treumatic	1 4	TERESA WALKER (NIECE) 1015 20a. Method of Disposition 20b. Place of Dispo	FOXWOOD LANE BALTI	-		
nor	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crei	natory or other place)		Oc. Location - City	·
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Skinature of Funeral Service Licensee 22	UNT CREMATORY MARC 2. Name and Address of Facility CA 412 E. PRESTON STR	ALVIN B.	SCRUGGS	FUNERAL HOME
			23a. Part1. Enter the disease, or complications that caused the leafn. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a	Arteny Disease			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				.32
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	on			Dyears'
/	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c. Autobase	Moll, tos			5 486KS
0,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	4.10.17.6			1
8760,	physic physic the b	dlcal	d				
O. Box 6	ath certifi ttending or use as	Physiclan/Med		Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
P.0.	uires that the de signed by the a td be detached f		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute	e to the cause of death?
Records,	quires n sign u/d be	ed by	Hypercholesterdemia				Probably 4 Unknown
900	aw requir as been si 2 should	Completed	Osteoarthron's		24a. Was an	24b. Were	autopsy findings available to completion of cause of
Ä	The lay ate has page 2:	Com			autopsy performe	ed? death	1?
/ita	ician: ertific ector,	Be	25. Was case referred to medical examiner?		h (Check only one)		
of	Physic this cral dir	٠ <u>۲</u>	1 Inpatient 2 ER/Outpatien		me 5 Residence		pecify)
OU	th. : After	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred	
Division of Vital	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospitel or Attending Physician: The within 24 Hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and c	as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of cedifies	29c. License number		. Date signed (Mo	
)	0		Man werld	D46444	2	-25-0	5
	.7		30. Name and address of person who completed cause of death (Item 23a) (Type, NING F. EVERE: ++ 2323 31. Date filed (Month, Day, Year) MAR 0 1 2005	orleans St	· Bal-	ta, md.	21224
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrate Signature	Acoust &			
	Registr	aı	MAR U 1 ZUUD PARA	18			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEB 28, 2005 **Physician** 2:30pSuzanne Burnside Jackson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Renaissance Gardens Catonsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Minnesota 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 ☐ M 2**汉** F 78 Yrs. 721-07-2879 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural" ~ " any injury or other traumatic average. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√∑ No Catonsville Be Completed by Funeral Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 709 Maiden Choice Lane RGT 334 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Storey Karl Ackerman Burnside 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21 Marshs Victory Ct. Catonsville, MD 21228 Terence George Jackson, III/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 3/1/05 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Koma Thomas Gregor 299 Frederick Road Baltimore, MD 21228

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician day Preumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably COPD Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 7 1 Yes this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After t Certification; 1 Natural 2 Accident 5 Pending investigation 2 No death. 1 Tes 24 hours after death e Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medica within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 30989 February 28 la mer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Ln Catonsvill Mula M Corporter
31. Day filed (Month, Day, Year) MD State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	Maryland / De	epartmen Pertificat				giene Reg. No. 00	5	06668
	.		1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		Kather	ine H.	Jewell				Februa		005	11:00 P ^M
يماذو	Examir		4a. Facility Name (If not institution, give	street and number	r)	4b. City,	Town, or Loc	cation of Deatl	1	4c. County of	f Death	
			Brightwood Ce					ville			timo	
	Funeral		5. Social Security Number 6. S 215-42-9561	ex 7.4 □M 21∑1F	Age (In yrs. last birtho	Months		ours Min.	(Month, Da)	7, Year) 1909	9. Birthpia Countr	ace (State or Foreign
	Director		Usual Residence of Decedent	71	95 Yr	<i>"</i>			SEP 3,	1909	Mar	yland
	yend **		10a. State 10b. County		10c. City, Town o	r Location					10	d. Inside City Limits
	Man H	ģ	Maryland Baltin	nore			Balt	imore				1 ☐ Yes 2 XNo
	1 #8 1 288	Directo	10e. Street and Number			10f. Zip				10g. Citizen of W	hat Countr	y?
	h wit	O	3900 Buckingha	ım Road			21207	7		USA		
	deat in the state of the state	Funerai	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S.	13. Was Deced	dent of Hispa	nic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race	- America , White, et	
9	after of the state		1 Never Married 2 Married	1 ☐ Yes 2.X tf Yes, Give]No		2. No S₁		,	Specify:		 Nhite
8	ure!;	d by	3∭Widowed 4 □ Divorced	Year or Dates								
21215-0036	"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. D	ecedent's Usua Give kind of wo fe. DO NOT us	al Occupation rk done durin se retired)	n ng most of woi	king	16b. Kind of Bus	iness/indu	istry
42	with!	Ę	Elementary/Secondary (0-12)	College (1-4o	r 5+) "	Teach				Educ	atio	\n
9	filed Hygi ther	ပိ	17. Father's Name (First, Middle, Last)		4	reach		. Mother's Nar	ne (First, Middle,	Maiden Surname		,11
an	d be ental	To B	Thomas Micha	el Hoff	man			Li	llian (Cecilia	Sau	ım
Maryland	2 should be filed within 72 hours after death with the Manyland end Mental Hygiene. is marked other then "naturel", or Iteme 23s or 28e-f ehow emmatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (1			lailing Address	(Street and			r, City or Town, S		
ž	permit. Peges 1 and 2 should be illed within 72 hours after death with the Maryien Depertment of Heelih end Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28e-f ehow apprintury or other treumatic event, the Madical Examiner must be notified at once.		Katherine L. Jewe	11-Presto	on/Daughter	2020	Broad	way, A	t. 7J.	New York	. NY	10023
Baltimore,	te de la company		20a. Method of Disposition		20b. Place of D		ne of		Date	20c. Location - C		
Ē	Pege int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Metro C	remator	y, Ind	c. 2/:	25/05	Baltim	ore,	MD
aĦ	permit. Depertn Imports eny inju		21. Signature of Funeral Service Licen	1500		22. Name an	d Address of	f Facility	of MD	Tno	-	
B	80 E € 8		Edward A Gre	gorchik		299 F	rederi	ick Roa	d Baltir	Inc. more, MD	212	228
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387	The law requires that the deeth certificate be executed ate has been signed by the attending physicien end page 2 should be deteched for use as the buriel-trensit	Completed by Physician/Medical		_ d								
9 X	deeth certifics attending ph d for use es t	¥.	IF FEMALE:	23c. If yes, outcom	e of pregnancy					23d. Date	of deliver	,
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death at time of death	3 ☐ Ectopic pr 5 ☐ Other (sp				Mont		ay Year
P.O.	thet the de led by the s deteched t	1ys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
σ.	signed b	Y P	Part II. Other significant conditions of	ontributing to death	but not resulting in ti	ne underlying c	ause given in	Part I.	23e. Did to	bacco use contrib	ute to the	cause of death?
rds	auire n sig uid bi	De d							1 🗆 Y	es 2□No 3	Probal	bly 4mknown
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æ	ysician: The lav is certificete hes director, pege 2	E							autop perfor 1 ☐ Yes	med? de	ath?	
ital	ilcian: Th certificate rector, pag	0	25. Was case referred to medical				26.	. Place of Dea	th (Check only or			
>	Physician: this certificated director,	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Outp	atient 3 DC	Other:	4☐ Hursing H	ome 15 Resid	ence 6 Other	(Specify)	
Division of Vital Records,	ter th	Ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Tim Pay Year) Inju	e of 2	8c. Injury at Work?		28d. Describe h	ow injury occurred	1	
Ö	andir parth. he fu	atic	2 ☐ Accident investigation			М	1 🗀 Yes	2 🗆 No				
Ξ	r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	289. Place Of I	njury - At home, farm etc. <i>(Specify)</i>	, street, factory	, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural i	Route Number,
	To the Hospital or Attending Phys within 24 hours atter death. To the Funeral Director: After this completaly filled in by the funeral di	S							24.00			Min.
	Hosp 4 hos Fune Taly fi	Medical	(Check only 2 Medical Exam	niner: On the basis	of examination and/o	eath occurred or investigation	at the time, d , in my opinio	ate and place on, death occu	, and due to the c rred at the time, c	ause(s) and man late and place, ar	d due to t	he cause(s)
	the the	Med	29b. Signature and title of certifier	and manner	stated.	290	c. License nu	mber		29d. Date signed	Month, Da	av. Year)
	N I I			2 6/17						_		2005
	(/		Souph 30. Name and address of person who	completed course =	death (from 02-) (T	roe Print'	200.	7517	0	1 015 2	, 4:	2003
	X		30. Name and address of person who Sh Alwin MAC	A CUP	1 A PO	0 X 6	303	ELL	16074	474	2	2220
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regig	ar's Signature					/		,
	Registi		MAR 0 1	2005	ar's Signature	Loan	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Edward Koger 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Road N/A Campfield Baltimore 7201 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 25, 1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Hours 1**1** M 2□F Days Months 83 247-26-9275 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Tes 2 No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7201 Campfield Road 21207 USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2☐No Yes. Give 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction abover 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Koger Robert Koger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7201 Campfield Road Baltimone MD 21207 Louise Koger WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State memorial Ark 4/05 Baltimore Courty, MD ' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Jicensee 22. Name and Address of Facility Funeral Flavior Belain Road, Sewice, P.A. Battmone MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRSA Septicemic Due to (or as a consequence of): Dialysis Graft Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ESRD on Due to (or as a consequence of Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? on lower extremities 24a. Was an Necrotic Vicerations autopsy performe 2 🗆 No 1□ Yes 2 No 1 Yes CAD 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 2 1 Yes 27. Manne of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification:

The law requires that the death certificate be executed use as the burial-transit the attending physician detached ğ signed b page 2 should Hospital or Attanding Physician: After this certific funeral director, death. after death Diractor: יה 24 hour. tha Funaral Dirac. יאר filled in by th

P.O. Box 68760.

Division of Vital Records,

Funeral

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Physician /Medical

Examiner

Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

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28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certified

29c. License number H0061312 29d. Date signed (Month, Day, Year)

DR. PURVI and address of person who completed cause of death (Item 23a) (Type, Print)

BRANCH FURNACE E Registrar's Sign Tar 2005

State Registrar

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/Med Exam		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location	of Death		4c	County of	Death	
		505 Stoney Hill	Court			Oder						nne Ar		
Funera			6. Sex 1 □ M 2 🛂 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of (Month,	Birth Day, Year)	9.	Birthp	lace (State or Foreign try) yland
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Dharisi		1. Decedent's Name (First, Middle, Last)	2. Date of D	0. 14110 01 00001
Physici /Medio		LANNY LAMOST KELLY	FEBRUA	
Examin	er	4a. Facility Name (If not institution, give street and number) HARFORD ROAD & FACTORY ROAD	4b. City, Town, or Location of Death GLEN ARM	4c. County of Death BALTIMORE
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8, Date of B	
Director		220.40.8683 1MM 2□F 62 Yrs. Usual Residence of Decedent	Months Days Hours Min. [Month, L	
yland		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
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d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show ent, the Medical Examiner rough to notified at		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	C
Maryland 21215-0036 to 2 shouts be filed within 72 hours at the and Mental Hygiene. Its marked other then "natural", or traumatic event, the Medical Exam.	e Co	17. Father's Name (First, Middle, Last)	ERATOR 18. Mother's Name (First, Middle	CONSTRUCTION le Maiden Sumame)
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NOTE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other then "natural", or Itams 23a or 28a-f show or other traumatic event, the Madical Examinations to notified at	l		ng Address (Street and Number or Rural Route Num	
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Physician		23a. Part1. Enter the diseas or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode or dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
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o death	sicla	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	Ectopic pregnancy Other (specify)	Month Day Year
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DIVISION C tor Attending P after death. Director: After d in by the funera	Certification;	determined 289. Place of Injury - At nome, farm, str. building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, own, State)
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To the H within 24 To the Fi complete	Medical	one) and manner stated.		
T With	-	29b. Signature and title of certifier	29c. License number OCME	29d. Date signed (Month, Day, Year)
12		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	FEBRUARY 26,2005
/"		MARGORITO D. KORFU		timore, Maryland 21201
Sta Registr		31. Date filed (Month, Day, Year) 1 2005 32. Refistrar's Signature MAR 0 1 2005	Sporte	

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1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury M 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Locat		hysic his ce I dire	0	1 ☐ Yes 2 ☐ Ho	Hospital: Inpatier	t 2 E	R/Outpatient 3[DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Res	idence	6 ☐Other (Spec	ify)
Sign of the property of the pr			on:		28a. Date of Injun (Month, Day	Year) 2	Injury	28c. Injury Work	al (?	28d. Describe	how injur	y occurred	
29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29a. Certiflier (Check only one) 29b. Signature and title of settler) 29b. Signature and title of settler) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	<u>s</u>	ten leal tor: the	icati	2 Accident investigat		- 445			Yes 2 □ No				
	2	ital or Al	Certif	4 Homicide determine	bullding, etc.	(Specify)				City or To	wn, State)	
		Hosp 24 hou Fune letely fill	dical	(Check only 2/ Megnical_Ex	aminer: On the basis of	examination	ledge, death occu on and/or investiga	rred at the timation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
		To th within To th compl	Me	29b. Signature and title of sertifies	A			2			29d. Dat	te signed (Month	Day, Year)
30. Name and address of person who completed cause of death (Item 23) (Type, Print) VENKAT. S. KAMANAN 1501 SURVATTS ROAD # 307 CUNTON MD State 31. Date filed (Month, Day Year) 1 2015. Register's Signature # MAR 0 1 2015.)			> / Well	/WD			<i>D</i> .	53885	-	d	2/15/	05
State 31. Date filed (Month, Day Year) 1 70032. Register's Signature & MAR MAR 1		2		30. Name and address of person wh	o completed cause of de	ath (Item,	23a) (Type, Print)	CAAT	75 la	AD # ?	07	Cunc	on MD
			te	31. Date filed (Month, Day Year)	1 2005 Regista	r's Signatu	ire & A	marke	12 1-01	V/ TI 3	- /	* - *	20735

					Please	Type or Pri					_		-	
				For		State of M	arylan			lealth and N	nental Hy	giene	nns	06672
				1 - State Registrar				Cei	tificate of	Death		Reg. No	,000	00010
		Physicia	an	1. Decedent's Name				77 - 1- 1	Too		2. Date of De. Month Februa	Day		3. Time of Death 10:00 PM
		/Medic		William		rederick e street and number)		Kohl,		r Location of Death	Tebrua		. County of Deat	1 - 0 - 0
		Examin	er			Medical		er	Towson			В	Baltimor	
		Funeral Director		5. Social Security N 212-20-72		Sex 7. Ag	ge (In yrs. 80	last birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, De June 1	y, Yeer)	9. Birt <i>Co</i> 924 Ma	hplace (Stete or Foreign untry) .ryland
		and w		Usual Residence of	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
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		death with the Maryland ims 23e or 28e-f ahow r nutt be notified at	Director	10e. Street and Nu					10f. Zip Code			10g. Cit	tizen of What Co	ountry?
		ath v	rai	620 Lake	e Drive	12. Was Decedent	Courte 1	10 12 1		21286	acifu Vae or No		USA 14. Race - Ame	nican Indian
		them them	Funeral	11. Marital Status	ied 212 Married	Armed Forces	?	J.S. 13.	f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, Whit	
	21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Mudical Examinet marke and lifed at ODGE.	by	3 Widowed		If Yes, Give Year or Dates:	1943-	-46	1 ☐ Yes 2 📉 No	Specify:			Specify: Wh	nite
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		filed v Hygie other i	Be Co	17. Father's Name	(First, Middle, Lasi			bupe	LVISUL	18. Mother's Nam	e (First, Middle			
1,	an	Aental Aental rked	ToB	William	n Fred	lerick	K	Coh1		Wilhelm	ina		Lantz	
-	Maryland	and N	_	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numb	er, City o	or Town, State, 2	Zip Code)
0		and 2 pailth n 27 i			t T. Kohl	/Wife				ve, Towso				
5	ore	t of H t of H if itan		20a. Method of Dis 1 X Burial 2		Removal from State		cemetery, crei	sition (Name of natory or other place	1	9705		ocation - City or	
William	Baltimore,	rtmen rtant: njury			5 Other (Speci		Dul	23	Name and Addre	i. Gardens				Maryland
7	Ba	Departiment Departiment Departiment Department					T.	emmon Fur	neral Hom	e of Du	lane	y Valle	y Inc. nd 21093	
3		W 151		23a, Part1, Enter	n W. Clar	plications that cause	d the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	riai y i.a	Approximate Interval Between
4	-	Physician		Immediate Cause disease or condition	(Final	one cause on each	watry	axavi	1 dai	Dune				Onset and Death
	7	/Medical		resulting in death)		Due to (or a	s consec	quence of):	1 600	ilune				1
_		Examiner	L	Eaquantially list or	onditions,	b. 141	ne	Cen	ulv					month
7		ed sit	nine	if any, leading to ir cause. Enter Und Cause (Disease or	mmediate ertying r injury	Due to (or a	s a consec	quence or):						LAGIANS
0		be executed sician and burial-transit	Examiner	that initiated event resulting in death)	S	c. Due to (or a	s a conse	quence of):			<u>-</u>			gerri
	209	e be e ysiciar e buri	a		•	d								
	68	ng phy as th	Medi	IF FEMALE:										
	Box 687	The law requires that the death certificate are bas been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	23b. Was deceder in the past 12 1 \sum Yes 2	2 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Fet	al death 3[]Ectopic pregnanc] Other (specify) _	у			23d. Date of de Month	livery Day Year
	P.O.	at the c by the	hys	9 ☐ Unknow	1	9□ Unknown								
		ires that the d signed by the d be detached	þ	Part II. Other signi	ificent conditions	contributing to death	but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did 1	,		o the cause of death?
	Ö	v requir been s should	Completed								24a. Was		24b. Were at	utopsy findings available
	Rec	The law ate has page 2	mp								auto	psy ormed?	prior to death?	completion of cause of
	a	ilcian: Th certificate rector, pag	e Co	25. Was case refe	ered to medical	-				26. Place of Dea	1 Yes		1 Yes	2 □ No
	₹	Physician: r this certifica ral director, r	0 0	examiner?	2	Hospital:	tient 2	ER/Outpatie	nt 3 DOA Ott	hor			6 ☐Other (Spe	cify)
	ιof	ng Phy ter this neral c	Ju: T	27. Manner of Dea		28a. te of In	iury	28b. Time o		ry at	28d. Describe	how inju	iry occurred	
	sioi	tendir leath. tor: Al	catic	2 Accident	investigate	ho	mirror As h			Yes 2 No	28f Location /	Stroot 21	ad Number or B	ural Route Number,
	Division of Vital Records,	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	4 Homicide	determine	d 289. Place of I	njury - At i etc. <i>(Spec</i>		reet, factory, office		City or To	wn, State	e)	urai Houte Number,
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		7/15	1	•		May	>	MD	u	93114		\mathcal{Q}	117105	
10	(11/		30. Name and add	dress of person who	completed cause of	death (Ite	am 23a) (Type	Print)	5.00	2000	01.1		D21204
				31. Date filed (Mo	nth. Dale Year	1 20 35 Regis	11054	alure	MODIFIE	ves 1	rach !	VILLA	N M	V4204
		St	ate	JI. Data med (MO	MININ	1 5000	,		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year UR. 9:21 PM KIMES **Physician** DUFFY L. 2005 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Glen If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Hrundel 5. Social Security Number Hrundel Hesp. tal Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/06/1944 6. Sex 1≜ M 2 ☐ F . Age (In yrs. last birthday) **Funeral** MD Yrs. 60 217-40-6330 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 → No **Funeral Director** ANNE ARUNDEL GLEN BURNIE MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21060 1913 NORMAN ROAD 12. Was Decedent Ever in U.S.
Armed Forces?

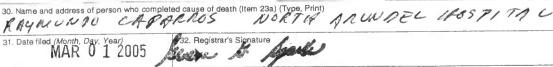
1 X X es 2 \(\) No 196
If Yes, Give
Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1962-WHITE 1 ☐ Yes 2 No 5 Specify: Specify: Baltimore, Maryland 21215-0036 Completed by 1966 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd 2 should be filed within Ith and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ANNE ARUNDEL COUNTY HEATING ENGINEER 18 Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DOROTHY CARTER DUFFY LEVANDER KIMES, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1913 NORMAN ROAD, GLEN BURNIE, MD of Health a MRS. LINDA KIMES / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page. Department o Important: If i any injury or once. MD VETERANS CEMETERY 03/02/2005 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA 21. Signature of Funeral Service Licensee Uchille & Corney - MO1415 1 SECOND AVE. SW, GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOGATHY Physician /Medical CORONARY

Due to (or as a consequence of): Examiner. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner STATUS POST CARDIAC burial-transit Due to (or as a consequence of) attending physician for use as the buria Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown RIGHT HEHI COLECTEM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? To the Hospitel or Attending Physicien: the funeral director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Mayor of Death 28b. Time of 5 Pending Natural 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Thomicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier

State Registrar

MAR 0 1 2005

RAYMUNDO



				epartment of Health and N Certificate of Death	Mental Hygie	21115 1	06675	
	Physicia		Decedent's Name (First, Middle, Last) BELLE	KUSHNER	2. Date of Death	^{Da} 25, 2 ⁰ 005	3. Time of Death 3:15 A M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4730 ATRIUM COURT #103	4b. City, Town, or Location of Death OWINGS	T	4c. County of Death		
Ī	Funeral Director		5. Social Security Number 214-14-4503 6. Sex 1 M 2 F 7. Age (In yrs. last birth		8. Date of Birth (Month, Day, Ye 06/08/191		ace (State or Foreign try)	
20	should be filed within 72 hours after death with the Maryland do Mental Hygiene. marked other than "naturel", or Items 23a or 28e-1 show matte event, it a Mazilicat Ext. after count be resilited as	Funeral Director	10e. Street and Number 4730 ATRIUM COURT APT. #103 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No	S MILLS 10f. Zip Code 21117 13. Was Decedent of Hispanic Origin? (Sp. ff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	Citizen of What Count S.A. 14. Race - America Black, White, 6	an Indian, etc.	
Maryland 21215-0036	filed within 72 hours a Hygiene. Ither then "naturel", c ant, the Moulest Extra	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	1 ☐ Yes 2 Å No Specify: Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) MEMAKER	ring	o. Kind of Business/Ind	ITE ustry	
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	nd 2 state at treu			Mailing Address (Street and Number or Rura 05 JOHN EAGER COURT		ity or Town, State, Zip E MD 2120		
altimore,	8°= 2			NAT A BENEVO'LENT	Date 20c	SEDALE MD	wn, State	
Balti	permit. Pa Departmen Important: any njury once.		21. Signature of Funeral Service Licensee		DL LEVINSO	N & BROS.,	INC.	
8760,	The law requires that the death certificate be executed Applying the strength of the attending physicien and the strength of	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	actor deser	or respiratory arrest,		Approximate Interval Between Onset and Death	
O. Box 6	the death certific y the attending p ched for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year	
ds, P.	n requires that the de been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	e cause of death?	
al Record		Completed	hypelipidenies	nay	24a. Was an autopsy performed	24b. Were autop prior to com death?	sy findings available apletion of cause of	
Division of Vital	두 두 등	Certification: To Be	2 Accident investigation	patient 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how in		ssted	
DIX	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,	
	e Hospi 24 hour e Funer letely fill	edical	29a. Certifier (Check only one) 1	death occurred at the time, date and place, for investigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)	
١	To the within To the comp	Me	29b. Signature and title of certifier Jan W Mule Mule	29c. License number	29d.	Date signed (Month, E	OS (Pear)	
	6		30. Name and address of person who completed cause of deats (Item 23a) (1	& Greene Thee	िर्ध न	£300 S	42 al	
• •	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2005	parke				

Samuel Litman 05-01397 dl

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			1 - State Amend Item 1&0	State of Marylar J npend Item 2	nd / Depa 3a , 2 <i>7 ei</i>	rtment of H 28a-f per tificate of l	lealth and me G84 Death	Mental Hyd 3-14-05	iene tas	5 06676
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	3. Time of Death
	Physici /Medio		SAMUEL	DARTH		I TPMAI	N	Februar	cy 23, 2	005 1:49 P M
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or		ith	4c. County	
			4500 Eli Drive Apt			Owings N			Baltim	ore
	Funeral Director		219-00-/321	7. Age (In yrs. 2!		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		979	Birthplace (State or Foreign Country) MD
)	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	the Marylan 28a-f show	호	MD BALTIMO	RF B	ALTIMOR	F				1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		12 (27)01	10f. Zip Code			10g. Citizen of W	hat Country?
	th with	a D	2710 SUMMERSON ROA	D		21209			U.S.A.	
036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28a-f show ta Mailcal Exemiter mail be maillied at	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	J	Vas Decedent of H i Yes, specify Cuba	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	Black	- American Indian, k, White, etc. WHITE
21215-0036	permit. Pagas I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netur any injury or other traumatic event, Ita Mazilcal once."	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	lent's Usual Occupi kind of work done o OO NOT use retired	during most of w	orking	16b. Kind of Bu	•
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ā	12 st thanc 7 Is n traun		19a. Informant's Name/Relationship (Ty)	•				Rural Route Numbe	- 1	
	1 and Health em 27 ther tr		ELAINE LIPMAN / GR 20a. Method of Disposition	ANDMOTHER 206.	_	SUMMERS(sition (Name of	JN KUAD	Date Date	RE, MD 2	CIZU9 City or Town, State
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Baltimore,	artme artme ortan injur		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 			. Name and Addres				STOWN, MD
ñ	permit. Departr Importa any inju		Robert /	Trans-)		CONTROL SECTION			ROS., INC. LE. MD 21208
18	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the deale cause on each line. Methadone in	th. Do not ent	er the mode of dyin				Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and burial-transit sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the to	quence of):					
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o	ding Phys	은	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Fo(1967) Day Year) 2.3-05	ER/Outpatien 28b. Time of Injury	unk 28c. Injun	4 LI Nursing	Home 5 Resid	ence 6 v the ow injury occurre	200110
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury - At I building, etc. (Speci	nome, farm, str ify)			28f. Location (S City or Tow	treet and Number n, State) 450(ills. MI	or or Rural Route Number, DELL Dr.,
	e Hospitel 124 hours e Funeral letely filled	dical (29a. Certifier (Check only only only only only only only only	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my of	ne, date and place pinion, death occ	ce, and due to the o	ause(s) and mar	nner as stated
	To the within 2 To the comple	Me	29b. Signature and title of certifier	\cap		29c. License	e number	2	29d. Date signed	(Month, Day, Year)
			10 Junho	m()		OCME			Februar	y 24, 2005
			30. Name and address of person who co	mpleted cause of death (Ite	т 23а) (Туре,	Print) 111]	Penn Str	ceet Bal		Maryland 2120
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 1 2005	32. Registrar's Sign	ature					

DHMH 17 Rev 1/2001

Registrar

FEBRUARY

EDGAR

LAMBERT,

Stephen.

2005

MAR 01

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUTARY Pay, 20/25 **Physician** \$4:30A HzIZU HOCERCIT び) いと /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a Facility Name (If not institution, give street and number) Saint Joseph Medical Cent **Examiner** 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 M 2 F MARY Yrs. Director 21/2 06 416 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercises must be notified at 1 ☐ Yes 2 No Director CARRAGO HARFOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.

The file of 15 marked other than "natural", or Itams 23a or itams 17 or other than "natural", or Itams 17 or other traumatic event. It is Net Italia for intent or other traumatic event. AD) U.S.A 21014 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10495 SILVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ HOMER ZOWARD HTZBALLI ScHWinb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bal A.R 1051 DAVID DOAS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State F20.28 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BELAIR PEM- GARDEN permit. Page Department of Important: If any injury or once. BILHIR 2005 * 4 Donation 5 ☐ Other (Specify) Mar. 21. Skingfur - Luneral Service Icens le 22. Name and Address of Facility CHROEL

STEWN FOR TORING FO RIPLISA 21050 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPSIS Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed MYELODYSPLASTIC SYNDROME Due to (or as a consequence of) Box 68760, for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P. 0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, sign I be 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 227 No 24a. Was an autopsy 1 Yes Hospital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 2 No death. 1 Tes after death Diractor: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To tha Funaral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 0 Ala m.O 2018 D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAR 0 1 2005 DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland	-	artmen tificate			and M		giene Reg. No.	005	06	679
	Physici		1. Decedent's Name (First, Middle, Last) CARL M. LAMBERT								2. Date of Dea Month Februa	ath ry Day	4, Ž065		of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give s Greater Baltimore		Cent	er		Town, or WSON	Location o	of Death		4c. C	ounty of Death altimor		
	Funeral Director		5. Social Security Number 6. Sex 213-10-4457 Usual Residence of Decedent	M 2□F	e (In yrs. Ia 88	est birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Pa) 1/16/19	y Year) 917	Cou	place (State ntry) V YORI	e or Foreign K
	the Maryland 28a-f show	rector	10a. State 10b. County MD CARROLL 10e. Street and Number			, Town or Lo		Code	·			10g. Citize	en of What Cou	1 □ Y	City Limits
	3e or		6307 WHITE CEDAR	COURT				1784	L			US		····· ,	
3036	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural" or items 23e or 28e-f show event, If a Medical Exaction must be rediffed at	d by Funeral Director		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	es? If Yes, specify Cuban, Mexican, Puerto F ⊠ No 1 □ Yes 2☒ No Specify: es:					cify Yes or No- Rican, etc.)	. 14	Black, White			
21215-0036	od within 72 P giene. er then "natu , Ir e Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12TH GRADE	cation o completed) College (1-4or 5	i+)	16a. Deced (Give life. I	kind of wor DO NOT us	I Occupa k done d e retired)	ition uring most	t of workii	ng		of Business/In		rs
Maryland 2	e da b	To Be (17. Father's Name (First, Middle, Last) WILLIAM LAMBERT						ALB	ERTA	(First, Middle, HILL				
Mar	d 2 sh thand 7 Isrr traum		19a. Informant's Name/Relationship (Ty) SHARON ROBISON/DA				ng Address WHI1				/ Route Numbe		Town, State, Zij RG,MD 2		
a,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R			ace of Dispo	sition (Nan	ne of	Ţ		ate		ation - City or T		
Ē	Pages tment of tant: If it jury or o		`4 □Donation 5 □ Other (Specify)		MOR	ELAND			1		5/2005				
Bal	permit. Departr Importu any inji		21. Signature of Funeral Service License	dans			521 L				E JOHNSO	ON FU WSON,		10ME, 1286	P.A.
	Physician /Medical Examiner	Je	23a. Part1. Inter the diseas or complishock, in heart failure. Ist only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate	cations that caused le cause on each ling. My DC Due to (or as	ardi a consequ eed	al in			, such as	cardiac o	r respiratory an	rest,		Approxim Interval E Onset an day	Between d Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	cause, Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):									
.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p from the Funerel director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3]Ectopic pr] Other (sp					23	d. Date of deliv Month	ery Day	Year
rds, P.	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions cor	atributing to death b	ut not resu	liting in the u	nderlying c	ause give	n in Part I.			obacco use /es 2 🗆	e contribute to to No 3 Pro		of death?
tal Reco	in: The law requilicate has been or, page 2 should	e Complet	25. Was case referred to medical						26 Place	of Death		rmed2 2 No	24b. Were autoprior to codeath?	impletion o	s available cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	To B	examiner?	ospital: 1 Sinpatio 28a. Date of Inju (Month, Da	ry	ER/Outpatier 28b. Time of Injury		8c. Injury Work	at UNu	rsing Hor	me 5 Resid	dence 6		fy)	
Divis	s after des s Directors al Directors	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory	, office	Sunt I Sec.	2	28f. Location (S City or Tow	Street and vn, State)	Number or Rur	al Route N	umber,
	ne Hospitel 7.24 hours a ne Funerel I Hetely filled	edical (29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sicien: To the best ner: On the basis o and manner st	f examinat	wledge, death ion and/or in	n occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ded at the time, d	cause(s) a date and p	nd manner as s place, and due t	stated. o the cause	9(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0				. License				- 1	signed (Month,	Day, Year)
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_	TO TO		30. Name and address of person who con Helen M. Goodc	M 6565	-N,	Chan	Print)	54.	Balt	\W9	ne wu	21	204		
	Sta Regist		31. Date filed (Month, Day, Year)	32. registr	ar's Signal	B. A	porti	ř							

				partment of Health and M e <i>rtificate of Death</i>		ene 0 0 5	06680
	Physici /Medic		1. Decedent's Name (First, Middle, Last) FLANK E. LEYK	BA	2. Date of Death Month	Day Year	3. Time of Death 6 55 A M
	Examin		4a. Fecility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL	4b. City, Town, or Location of Death LAUREL		4c. County of Deat	GEORGE
	Funeral Director		5. Social Security Number 193-20-6685 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthda 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, March 5,	Year) 9. Bin Pen	hplace (State or Foreign buntry) NS YLVANIA
	aryland show	7.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-f	Funeral Director	MD Prince George Lawrel 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	<u> </u>
	eath w	erail	8482 Snowden Oaks Place 11. Marital Status 12. Was Decedent Ever in U.S. 13	20708 3. Was Decedent of Hispanic Origin? (Sos	acify Yes or No-	USA 14. Race - Ame	nican Indian
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or liems 23a or 28a-f show imatic evant, the Medical Examinat must be notified at	þ	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Never Dates:	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto X□ Yes 2□ No Specify: Cub		Black, Whit	
215-0036	filed within 72 hor Hyglene. other than "nature ant, the Medical E	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of worki b. DO NOT use retired)	ing 1	6b. Kind of Business/	Industry
121	filed withi Hygiene. other than			rinter 18. Mother's Name	/First Middle M	Publica	tions
Maryland	should be find Mental Harkad of	To Be	Francis E. Leyba	Lillian	r P. Mye	rs	
Mar	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic			iiling Address (Street and Number or Rura 2 Snowden Oak Place			
ore,	es 1 ar of Hea f Item 3 r other					Oc. Location - City or	
Baltimore,	permit. Pages Department of Important: If It any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Cemetery 2/18/ 22. Name and Address of Facility To			ennsylvania
eg —	Departing Department of the suny in su		20HBLE	7601 Sandy Spring R	Road, Lai		land 20707
	Physician		23a. Part1. Enter the disease, or complications that agused the death. Do not a shock, or heat failure. List only one cause of each line. Immediate Cause Final disease or condition	onter the mode of dying, such as cardiac of	or respiratory arre	st.	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (gr as a consequence of):	MA/OF LUX	<i>sa</i> .		MERE
	be isi	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ed Euphy.	lone		10 WARS
90,	cate be executed physician and the burial-transit	al Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	at Confine	1011		10,2
68760		edical	d	•			
O. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	ivery Day Year
٦.	res that the de igned by the a be detached f	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	
Records,	w require been signature	eted			1 XYes 24a. Was an		topsy findings available
		Completed			autopsy perform	ed? prior to death?	2 No
Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	26. Place of Death			
on of	Attending Physician: or death. actor: After this certifica by the funeral director. I	\vdash	1 Yes 2 No 1 No 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	me 5∐ Resider 28d. Describe hov	nce 6 Other (Spec	cify)
Division of	l or Attendi after death. Diractor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	Medical C	29a. Certifier (Check only one) Check only one) And manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the comple	Me	295. Signature and title of certifier	29c. License number 1) 19 25 2		d. Date signed (Month	
1	2+1		30. Name and address of person who completed cause of death (Item 23a) (Type RONGLTO A DEPETRICE M.)	e, Print) 300 GALLANT FOXI	4#122	BOWIEH	1020715
Í	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Residera's Signature	1) 1923 Z 300 GALLANT FOX L	-1		

		•	_ FOI	partment of Health and Meartificate of Death	ental Hygier	2005 00001
П			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		WILLIAM RICHARD LEWIS		FEBRUARY	21 2005 11:35 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			3371 CRANBERRY SOUTH	LAUREL J If Under 1 Year If Under 24 Hrs. p		ANNE ARUNDEL
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 6. Tr. 4 2 F 6.3 Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea SEPT 21, 1	9. Birthplace (State or Foreign GOUNTY) 941 WASHINGTON. DC
			Usual Residence of Decedent		301112131	THE WHOTEHOTON, DO
	rylan show		10a. State 10b. County 10c. City, Town or ANNE ARUNDEL LAUREL	Location		10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f s	cto				
	with ti	by Funeral Director	10e. Street and Number 3371 CRANBERRY SOUTH	10f. Zip Code 2 0 7 2 4		Citizen of What Country? USA
	leath	erai		. Was Decedent of Hispanic Origin? (Spec		14. Race - American Indian,
ယ	or item	Fu	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White, etc.
<u> </u>	ral', c	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:		Specify: WHITE
5-0	within 72 hours after death with the Maryland ene. than "natural", or tlems 23e or 28e-f show the Mudical Examination and the indiffed at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working	g 16b.	. Kind of Business/Industry
12	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	DONOTuse retired) OSTAL WORKER	119	POSTAL SERVICE
р 5	filed Hygir other		17. Father's Name (First, Middle, Last)	18. Mother's Name (
lan	ould be Mental arked c	To Be	HARVEY E. LEWIS	ELEANOR	T. LEWIS	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, It is Nortical Examinating the Political at		1.1.21	iling Address (Street and Number or Rural		
Σ,	1 and 2 Health tem 27 l			1 CRANBERRY SOUTH, 1		
Baltimore,	ges 1 t of H if Iter or oth		1 M Burial 2 I Gremation 3 I Hemoval from State 1	ematory or other place)		Location - City or Town, State
Ë	t. Pag rtmen rtant: rjury		`4 ☐ Donation 5 ☐ Other (Specify)	OLN CEMETERY 2/24/0		ENTWOOD, MARYLAND
Bal	permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other gange.	d		22. Name and Address of Facility FLE(7601 SANDY SPRING RO		
Г			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or seath failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	å 74	Immediate Cause (Final disease or condition resulting in death) aPANCREATIC ADRNO	LARCINOMA-METASTATIO	C STAGE I	
	/Medical Examiner		Due to (or as a consequence of):			
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
oʻ	an an rial-tr		resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai			-	
9	death certifica attending plants of for use as t	Med	IF FEMALE:			
Вох	ath ca attend for us	Physician/Me	in the past 12 months?	B Ectopic pregnancy Dipole Other (specify)		23d. Date of delivery Month Day Year
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	requires that the veen signed by th hould be detache	by Ph	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
rds	w requires that been signed t should be det	q pa	ANEMIC LIVER FAILURE		1 🗆 Yes	2 No 3 Probably 4 Unknown
900	e faw re has bee je 2 sho	piet	ANORIXIA CACHIXIA		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
of Vital Records,	Th ate pag	Completed			performed	? death? No 1 Yes 2 No
/ita	sician: Th certificate irector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
of \	S S S	ပို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			
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Division	Attending or death.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm,		Bf. Location (Street	and Number or Rural Route Number,
<u>S</u>	⊇ # 15 :⊆	Certification:	4 Homicide building, etc. (Specify)	,	City or Town, St	ate)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, ar investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	a(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)
	r > F O		Dank. Mund I MD	Er208 a	2	-22-05
	NY		30. Name and ddress of person who completed cause of death (Item 23a) (Typ			
_	171			PATUXENT PARKWAY,	COLUMBIA,	MD 21044
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regigans Signature MAR 0 1 2005	Sporte		

			For State		State of	Marylan	-	artmen	t of H	ealth a		lental Hyg	giene	n S	06682
			Registrer 1. Decedent's Name (i	First, Middle, Last	')			incat	01 2	Jean		2. Date of Dea	Reg. No. U	UU	3. Time of Death
	Physici			n Lanhar								Month Februar	Day	2005	8:55 A M
	/Medio Examin		4a. Facility Name (If no			oer)		4b. City.	Town, or	Location of		rebruar		ty of Death	
	Exami	er		v Haven I					ssex					altim	
	Euparal		5. Social Security Num			Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birtl			
l,	Funeral Director		407-56-009 Usual Residence of Do	97	□ M 2 🟋 F	62		Months	Days	Hours	Min.	8. Date of Birtl Jan. 6,	1943	Ken	place (State or Foreign intry) tucky
	and and			0b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f sh	0	Maryland	Baltimon	re		Esse	v							1 ☐ Yes 2√☐ No
	28a	Funeral Directo	10e. Street and Numb					10f. Zip	Code				10g. Citizen o	of What Cou	into/2
	With Sa or	۵	2017 New H	Jarron Dre	i					221				USA	, .
	leath ns 2; mus	era	11. Marital Status	laveli bi.	12. Was Deced	ent Ever in U	.S. 13.	Was Deced	_		ain? (Sp	ecify Yes or No-		ace - Ameri	ican Indian
	ter c	ᇤ	1 Never Married	2 ☐ Married	Armed Forc	es?		f Yes, spec	ify Cuba	n, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)	В	lack, White	
36	urs a	by	3 X Widowed 4 ∣	_	If Yes, Give Year or Dat			1 ☐ Yes 2	2⊠ No	Specify:			Spe	city: Wh	ite
215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f show the Madical Examinar must be notified at	ted		5. Decedent's Edu	ucation		16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of	Business/Ir	ndustry
215	hin 7	ple	Elementary/Second	onfy highest grad	College (1-4	lor 5+)		kind of wor DO NOT us	nk done d se retired	luring mos)	t of work	ing			
21	d wit	Completed	, , , , , , , , , , , , , , , , , , ,	, (0,	2		L.I	P.N.					Priva	te Du	ty
	e file loth vent	Be C	17. Father's Name (Fig.	rst, Middle, Last)						18. Mothe	r's Name	e (First, Middle,	Maiden Sum	ame)	
<u>a</u>	Aents Aents rked tice	70 E	Harry I	. Hattor	ח					E	ffie	Claypo	ol		
Maryland	am s man		19a. Informant's Nam	e/Relationship (T)	ype, Print)		19b. Mailin	ng Address	(Street a	and Numbe	r or Rur	al Route Numbe	r, City or Tox	m, State, Zi	p Code)
	alth a		Bettina Te	ebo, Daug	ghter		43 Wa	ide Av	enue	e Cat	onsv	ille, M	arylan	d 212	28
re	item		20a. Method of Dispos			20b. F	Place of Dispo					Date	20c. Locatio		
E	Page nent c nt: If ry or		1 ☐ Burial 2 🛣 0 `4 ☐ Donation 5			ale	ro Cre				02/2	6/05	Balti	more.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "naturat, or Items 23a or 28a-1 show any njury or other traumatic event, the Macical Examinat meat be notified at ance.	l	21. Signature of Fune	ral Service pens	600								1 -	orc,	. Kary zana
m	Department of the control of the con		Thomas	Gregor			25	emati 9 Fre	on t	ocle ick R	ty O	f Maryla Baltimo	and In	C. rvlan	1 212 2 8
			23a. Part 1. Enter the	disease, or comp	lications that cau	sed the deat	h. Do not en	er the mod	e of dyin	g, such as	cardiac	or respiratory an	rest,	L y Lair	Approximate
	Pnysician		Immediate Cause (Fig	'ailure. List only o nal	ine cause on eac	ar iine.	1 ac 1	1							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	-	a	as a cons	1041 L	41016							
	Examiner	П			200 10 (0	45 4 55115	Loan	tic (100.0
	#	ē	Sequentially list cond if any, leading to imm	itions, ediate	b. Due to (or	as a conseq	uenc of):	, , ,	-						1
	uted J ansit	듣	Sequentially list cond if any, leading to imm cause. Enter underly Cause (Disease or injustrat initiated events	ury			- 4							-	1
<u></u>	execunation and ital-tra	Examiner	resulting in death) Las	st	Due to (or	as a conseq	juence of):								
8760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal			d								_		
68	tifical g phy as th	ed													
Вох	leath certifica attending phi I for use as th	2	IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, outco	me of pregna		75-4					23d. I	Date of deliv	very
m.	death e atte	Physician/M	in the past 12 m 1 Tyes 2 BN		4□Pregnai	nt at time of d]Ectopic pr] Other <i>(sp</i>					1	Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 🗌 Unknown		9□ Unknov	'n									
٠ <u>٠</u>	signed l	by P	Part II. Other significa	ant conditions co	ntributing to dea	th but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	bacco use co	ontribute to 1	the cause of death?
ğ	w require been sig should b	ed										1 🗆 Y	es 2□No	3 🗌 Pro	bably 4 Unknown
Records,	sw request speed	Completed										24a. Was	an 24	o. Were aut	opsy findings available
ď	9 4 9	mo											med?	death?	ompletion of cause of
of Vital	ician: Th certificate ector, pag	O	25. Was case referred	d to medical						26 Place	of Death	1 Yes		1 🗌 Yes	2 No
5	Physician: this certificantal director,	To B	examiner? 1 ☐ Yes 2 ☑ No	1	Hospital:	nationt 2	ER/Outpatier	nt 3 DC	Othe			me 5 Resid		thor /Space	(6.1)
of			27. Manner of Death		28a. Date of (Month)		28b. Time o		8c. Injury Work	at at		28d. Describe h			'y)
o	rb.: Afte	tlo	1 KNatural 2 ☐ Accident	5 Pending investigation	(Month)	Day Year)	Injury	М		<br Yes 2 🔲	No				
Division	Attending r death. sctor: After by the fune	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be	286. Place o	f Injury - At h	ome, farm, sti	eet, factory	, office			28f. Location (S	treet and Nu	mber or Rur	al Route Number,
Ö	al or	ert	4 🗌 Homicide		pullainé	, etc. (Speci	(y)					City or Ton	n, State)		
	spita nours nera / fille		29a. Certifier 1	Certifying Phy	/sician: To the b	est of my kno	owledge, deat	h occurred	at the tim	ne, date an	d place,	and due to the o	ause(s) and	manner as :	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 one)	☐ Medicel Exam	iner: On the bas and manne	is of examina	ation and/or in	vestigation,	in my of	oinion, dea	th occur	ed at the time, o	date and plac	e, and due t	to the cause(s)
	To th To th comp	Me	29b. Signature and tit	le of certifier	11			290	. License	number	-		29d. Date sig	ned (Month,	Day, Year)
			1	Ad Ili	Win				038	345	9		Februa	n 25	2005
	\n		30. Name and addres	s of person who c	ompleted cause	of death (Iter	n 23a) (Type.							1	2005
	¥		To		1/62 163	SE 618	eno Tr	ee R	oad	Svite	400	Baltino	e,mn	2120	8
	Sta Regist		31. Date filed (Month,		32. R	gistrar's Signa	m 23a) (Type,	parte	,						

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artmen rtificat				Reg. No.	000	0668	33
	Physici	an	Decedent's Name (First, Middle, Last Touring Co.)	τ - 1				2. Date of De Month	Day		3. Time of De	
	/Media	al	Louise 4a. Facility Name (If not institution, give	atenat and number	Lednum	Ab Cibe	Tours	Location of D	2	25	2005 County of Death	3 1	А м
	Examir	er	120 Martha Road	street and number)				rnie	eatti		nne Arun	đe1	
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthday)	If Under	1 Year	If Under 24		th		place (State or F	oreign =
	Director		213-28-2887]M 2□F	93 Yrs.	Months	Days	Hours A	Min. (Month, Da				
	pu 🗼		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	anation.				, -,		10d. Inside City	Limita
	sho	ō	MD ANNE AH	RUNDEL	GLEN BUE							1 ☐ Yes 2	
	28a-1	ect	10e. Street and Number			10f. Zip	Code			10g Citi	zen of What Cou		
	3a or		120 MARTHA ROAD				060			US			
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show deal Exar it wit must be notified at	Funeral Director	11. Marital Status	12. Was Decedent		Was Deced	lent of H	ispanic Origin	? (Specify Yes or No	-	14. Race - Ameri		
9	after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🐼 I If Yes, Give	No	1 ☐ Yes 2		n, mexican, r	uerto Rican, etc.)		Black, White,	etc.	
003	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:		10,100	ZA: NO	Specify.			Specify: WHI	TE	
21215-0036	c * M	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usua kind of wor DO NOT us	k done d	durina most of	working	16b. Ki	nd of Business/In	dustry	
12	within lene. than "	щ	Elementary/Secondary (0-12)	College (1-4or 5	0+)	IEMAKE		,		пом	EMAKER		
9	should be filed within and Mental Hygiene. marked other than matic event, I as M	a)	17. Father's Name (First, Middle, Last)		1101		120	18. Mother's	Name (First, Middle,				
au	ould be i Mental i Marked o	ToB	JAMES COLLINS					WILLIE	RUTH BUR	TON			
Maryland	2 should and Men is marke sumatic	_	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address	(Street		r Rural Route Numbe		r Town, State, Zip	Code)	
	127 E d		ELSIE HAMMELL/ DAU	GHTER	120 N	ARTHA	ROA	D, GLE	N BURNTE,	MD :	21060		
Baltimore,	0 0		20a. Method of Disposition 1 XBurial 2 Cremation 3.	Removal from State	20b. Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther plac	e) MA	RCH 1,	GLEN	BURNIE,	wn, State MARYLA	ND
ij	permit. Pag Department Important: B any infury o		`4 ☐Donation ⊃ Other (Specify)		GLEN HAV				2005				
Bal	Depar Impor any in		21. Signature Fundal Service Licens					s of Facility	L HOME GL		ND AVENU		
	40244		23a. Part1. Enter the dispase, or comp								UKNIE, M	Approximate	
			shock, or heart failure. List only o Immediate Cause (Figal	ne cause on each li	ne.		esse V	_	ongo or roopingtory a	,,,		Interval Between Onset and Dea	
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	RING	700	mile					
8	Examiner			HUD	SOTENE	(NO)							
	P ==	ner	Sequentially list conditions, it any leading to immodiate cause. Enter Underlying Cause (Disease or injury	b. Duse to (drais	a nonaequanna of):	122.4							
	ecuter Ind trans	Examiner		c									
8760,	ate be executed hysician and the burial-transit	E E	resorting in death) Last	Due to (or as	a consequence of):								
87	physi physi s the t	dicai		d									
9 xo	eath certific attending p I for use as 1	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of delive	any	
B	death atter	clar	in the past 12 months?	4☐Pregnant at		⊒Ectopic pro ☐ Other (sp					Month	Day Yea	ar
0	t the de by the tached	hys	9 Unknown	9□ Unknown									
S, D	The law requires that the death certificate has been signed by the attending places as should be detached for use as I	by P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	ındərlying ca	ause give	en in Part I.	23e. Did to	obacco u	se contribute to the	ne cause of dea	th?
ecords,	w require been si should l		Jenevino.						_ 1□`	Yes 2	ANo 3 □ Prob	ably 4 Unk	rnown
S	e law r has be	Completed	1010101 B	EN VO					24a. Was autop	osy	24b. Were auto	psy findings ava	ailable se of
A IE		Con							perfo 1 ☐ Yes	200 No	death?	2□ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			. Othe	n. P1	Death (Check only o				-
of	Phys r this ral di	To I	1 Yes 21 No	1 🔲 Inpatie			A	4 🔲 Nursin	ng Home Resident Resi		3 □Other (Specify occurred	y)	_
on	Attending F r death. sctor: After by the funer	ıtlor	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	М	8c. Injury Work 1 🔲 '	k? Yes 2 □ No		,	,		
Division	Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, farm, st c. (Specify)	reet, factory	, office		28f. Location (S City or Tov	Street and	d Number or Rura	I Route Number	r,
ā	tal or A s after al Direct	Cert	4 _ 1 totalolds	Dullowig, et	с. (Эрвспу)				City of 104	vii, State,	,		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exert	sicien. To the best	of my knowledge, deat f examination and/or in	h occurred a	at the tim	e, date and pl	lace, and due to the	cause(s)	and manner as si	tated. the cause(s)	
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner st	ated.			number					
	To To	-	250, Signature and fille of certifier	N -		290	. Liverise	C)	2	Lou. Dat	e signed (Month,	Day, rear)	
7	./		30 Name and address of allocation	moleto con or	looth (Itom 33c) (Torre	Priot)	2)2	578		O (12210	>	
	5		30. Name and address of person with a STECHON 12-31 0	75		E AV	artu	or 6	SLEN BURG	118	maryl	5 00g	106
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		~ N P	,	- 30.00	416	V 1 V		
	Regist		MAR 0 1 2005	Marine	H. Book	2							

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	olato ol marytan	Cen	tificate of	Death		Reg. No	00=	000	0.1
	Physicia	ın	1. Decedent's Name (First, Middle, Las	JAMES B.	LAUBHI	EIMER		2. Date of De Month Februar	Dav	Yeer 2003	19:08	Peatiff*
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Baltime	r Location of Death			County of Death		
	Funeral Director		5. Social Security Number 6. Se X	7. Age (In yrs. I	ast birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bid (Month, Da 05-10-	1921	9. Birth	place (State or ARYLAND	Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation					10d. Inside City	Limits
	Ba-f eho	Director	MD. BALTIM	ORE		PARKVIL	LE		10- 0%	(110)	1 🗆 Yes	XX No
	ath with the 23e or 2	rai Dire	10e. Street and Number 8751 LACKAWA				1234			U.S.A.		
900	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23s or 28s-f show other traumatic event, the Medical Examinat must be invitible at	by Fur	11. Marital Status 1 □ Never Married ★★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 194	.2-	/as Decedent of H Yes, specify Cuba □ Yes XX No	lispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No o Rican, etc.)		4. Race - Amer Black, White Specify: W		
21215-0036	d within 72 h giane. ir than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give k	O NOT use retired	during most of wo	rking	BAL	od of Business/I TIMORE ARTMENT	COUNT	
Maryland	1.2 should be filed within " h and Mental Hygiene. 7 Is marked other than " fraumatic event, tha Mec	To Be C	17. Father's Name (First, Middle, Last)	IAM J. LAUB	HEIMER		18. Mother's Nat MARG		, Maiden S ILLIS			
	f and 2 shou Health and N tem 27 Is ma		19a. Informant's Name/Relationship (7 SUZANNE L. LAUBHE				a <i>nd Number</i> or <i>Ri</i> NA AVENUI					34
Baltimore,	00-5		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crem	ition (Name of atory or other place ERVICE C	ORP. 03-0	Date 01-2005		SON, MD.		
Balti	permit. Pag Department Important: I eny in ury o		21. Signature of Funeral Sergice Licen	see		Name and Addre	on FUNER	AL HOME,	INC	1050 YO	ORK RO	
Q.	Physician		23a. Pert 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	olications that caused the deatl one cause on each line. RESFIRATOIS		r the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Betw Onset and D	een
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	.,						
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	ENCE	PHALOPI	1 T Y				
68760,	death certificate be executed e attending physician and of for use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):		IAC ARE					
	artification phy a set the	Medi	IF FEMALE:									
O. Box	he death cer rithe attendir ched for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify) _	/		2	3d. Date of deli Month		ar :
s, P.O.	res that the de signed by the a be detached t		Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause giv	ren in Part I.	23e. Did	tobacco us	se contribute to	the cause of de	ath?
ord	w requires been sign should be	ted t	HYPERTENSION , /	ATRIAL FIBRILL	ATION	POLYM	YALCIA	10	Yes 2	No 3□Pro	bably 4 🗷 Ui	nknown
of Vital Records,	e las has je 2	Completed by	RHEUMATICA					24a. Was auto perf	psy ormed?	24b. Were autoprior to death?	topsy findings a ompletion of ca	variable use of
/ita	ysician: Th is certificate director, pag	Вес	25. Was case referred to medical examiner?					ath (Check only	one)			
of \	hys this	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Minpatient 2		3 DOA Ott	ner: 4 ☐ Nursing I				ity)	
Division	fter fter inel	sation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		28b. Time of Injury	28c. Injur Wor M 1	ry at rk? Yes 2 □ No	28d. Describe				_
Divi	tal or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location City or To	Street and wn, State)	d Number or Ru	ral Route Numb	er,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical		nysician: To the best of my kno niner: On the basis of examina and manner stated.		estigation, in my o	opinion, death occi		date and	place, and due	to the cause(s)	
	Tot Tot	Σ	29b. Signature and title of certifier Viyery 1949	MD		RES -			29d. Date	signed (Month	Day, Year) Drugry 27	2005
	127,		30. Name and address of person who	completed cause of death (Iter 560) , LOCH RA			, BALTIM	ORE MI	D 21:	239		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature			· · · · · · · · · · · · · · · · · · ·				
	Regist	-	WAR 01	2005 Meeur	D. 14	perce						

DHMH 17 Rev 1/2001

			1 - State Registrar	of Maryland / De	epartment of F Certificate of			nè 0 0 5	06685
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Thelma Helen Morken				2. Date of Death Month February	Day Year 25, 2005	3. Time of Death 10:15 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and	number)		r Location of Death		4c. County of Death	1
	Funeral		Lorien - Bel Air 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Bel A	If Under 24 Hrs.	8. Date of Birth	Harford 9. Birth	nplace (State or Foreign
	Director		212-20-6871 1 M 2 F	80 Yrs	Months Days	Hours Min.	(Month, Day, Y Mar. 11,	ear) Coi	ryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	e Mar	Director	Md. Harford	Bei	l Air				1 ☐ Yes 2 ☐ No X
	with the or 2		100. Street and Number		10f. Zip Code 210	115	10g	U.S.A.	untry?
	death	Funeral		ecedent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		cify Yes or No-	14. Race - Amer	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Exerticust Legical Legical at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes,	s 2√2 No		Specify:	Hican, etc.)	Black, White	o, etc. nite
Maryland 21215-0036	hin 72 ho e. en "natur Medicel	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	nd) (G	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	during most of worki	ng 16	b. Kind of Business/l	ndustry
21	filed wit Hygien other the		12 years 17. Father's Name (First, Middle, Last)		nager	10 Mark at No.		state gove	ernment
ano	ld be fi ental H ked ot ic ever	To Be	John Larsen Morken			18. Mother's Name Emily Pe		iden Sumame)	
ary	2 should I and Men Is marke sumatic	-	19a. Informant's Name/Relationship (Type, Print)		lailing Address (Street			ity or Town, State, Z	ip Code)
	1 and 2 Health Iem 27 I		Bernard J. Sampson - n	*	46 Chesney				
חסיי	Pages of hont of hint; If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	III State	isposition (Name of crematory or other place od Cemetery			c.Location - City or 1 Baltimore	G- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Baltimore,	permit. Pages i and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er		21. Signature of Funeral Service Licensee	Tarkwo	22 Name and Address	ss of Facility		Bel Air,	
	707 e d		23a. Part1. Enter the disease, or complications that	at caused the death. Do not	610 W. Ma	cPhail Ro	ad, Bel	Air, Md.	21014 Approximate
	Physician		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition	n each line.			•	•	Interval Between Onset and Death
	/Medical Examiner		regulting in death)	METASTATI to (or as a consequence of):	CISCAI	DURIC C	Mock		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):	:				
	acuted ind transit	Examiner	that initiated events						
68760,	ificate be executed g physician and as the burial-transit	edicai Ex	d	to (or as a consequence of):					
_			IF FEMALE:						
P.O. Box	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months?	outcome of pregnancy e birth 2 Fetal death egnant at time of death known	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliver Month	very Day Year
	res that the de signed by the a be detached f	by Ph	Part II. Othar significant conditions contributing to			en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	ted	HYPERTENSION,	Diabetes in	ellitus	 	1 ☐ Yes	2□No 3□Pro	bably 4 Unknown
Vital Records,	Physician: The law rrthis certificate has b sral director, page 2 si	Completed					24a. Was an autopsy performe	d? prior to co	opsy findings available ompletion of cause of 2 No
Vita	sician	Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No Hospital:	☐ Inpatient 2 ☐ ER/Outpa	other all Doa Other	26. Place of Death		a denu ca	ity) ASSISTED
Division of	ding Phy h. After this funeral d	tion: To		te of Injury Ionth, Day Year) 28b. Tim Inju	e of 28c. Injury	4 🗆 Nursing Hon	ne 5 Residence 28d. Describe how		LIVING
Divisi	To the Hospital or Attanding Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, to the funeral director, the funeral director director, the funeral director director director, the funeral director	Certification;	3 Suicide 6 Could not be 28e. Pla	ace of Injury - At home, farm ilding, etc. (Specify)	, street, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rui State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 12 Cartifying Physician: To Check only and m	the best of my knowledge, de basis of examination and/oanner stated.	eath occurred at the timer investigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th within To the compl	\$/			29c. License	number	29d.	Date signed (Month,	Day, Year)
	, 110	0	· Mulliange	en MD	D 45	344	0	2/25/20	205
	M,		30. Name and address of person who completed constructions of the second	ause of death (Item 23a) (Ty AD 622 S Begistrar's Signature	pe, Print)	AVE 11.	ANRE N	CRAPE	10 2017A
	Sta		31. Date filed (Month, Day, Year) 32	. Polistrar's Signature	South .	177	11.00	71-11-1	100119
	Registr	ar	MAR 0 1 2005	REPUBLICA ST.	HOWEL				

				State of Maryland / Department of Health and 1- State Registrer State of Maryland / Department of Health and Certificate of Death		2000 00000
				1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No. 3. Time of Death
	ш	Physici		Annie Belle McVeigh	Month	Day Year
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Death
		Exami	iei	MARINER HEALTH BELAIL BEL AIR		14 Ac food
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 funder 24 Hr		th 9. Birthplace (State or Foreign
		Director		231-10-7449 1□ M 2⊠ F 89 Yrs. Months Days Hours Mir	Dec. 1	8, 1915 South Carolina
		p ,		Usual Residence of Decedent		
		aryla shov	-	10a. State 10b. County 10c. City, Town or Location 10c. Ci		10d. Inside City Limits
		the Marylar 28a-f show	ecto	BCI AII	1	1 ☐ Yes 2 ☑ No
	3	Mith t	ä	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
		eath w	erai	1114 Glastonbury Way 21014 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Crosity Van ar Na	U.S.A.
		after des or Itams	Ę,	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 12. Married 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, White, etc.
	39	irs af	by Funeral Director	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		Specify: white
	21215-0036	be filed within 72 hours after death with the Maryla ital Hygiens and a that are a seed of other than "natural, or itams 23a or 28e1's how event, I'm Medical Ever, it wit must be redified at	Be Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
	215	within 7 ene. than "r	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of w life. DO NOT use retired)	onking	
	21	ygien Agrith	Con	4 Executive secretary		Steam ship company
	pu	d oth	Be		ame (First, Middle,	, Maiden Sumame)
	yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "natural; or Itams 23a or 28a-f show aumatic evant, Its Medical Evant within the Colling and	은		Bryan	
		2 sh and ls rr raum	2	19a. Informant's Name/Relationship (Type, Print) Joan Hayden/daughter 19b. Mailing Address (Street and Number or F		
		es 1 and 2 should b of Health and Ment f Itam 27 Is marked r othar traumatic e		Joan Hayden/daughter 1114 Glastonbury Way 20a. Method of Disposition 20b. Place of Disposition (Name of	, Bel All	
	altimore,	Pages nent of thint: if its int: if its		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City or Town, State
	Him	it. Pa rtmer rtant njury	. 1	`4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Gdns 21. Signature of Funeral Service Licensee 22. Name and Address of Facility		
	Ва	permit. Pages 1 Department of F Important: If Ita any injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funera	1 Home of	f Bel Air, Inc.
			-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	Road, Be	L Air, Md. 21014
_		5 5 7		snock, or near tailure. List only one cause on each line.	as or reopiratory a	Interval Between Onset and Death
	'	mysician /Medical		disease or condition resulting in death) a		10 years
10000		Examiner		Due to (or as a consequence of):		,
			i i	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		uted d ansit	Examiner	cause. Emer Underlying Cause (Disease or injury that initiated events c		
	o,	cate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):		
	68760,	icate be physicial the bu	dicai	d		
W				IF FEMALE:		
-	Вох	leath certiffi attending p I for use as	an/N	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
5	Э. Е	that the death certif ed by the attending detached for use as	Physician/M	in the past 12 months? 1		Month Day Year
3	Θ.	that the	Phy		an Did	
I	S,	ires tha signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	į	obacco use contribute to the cause of death? Yes 2 No 3 □ Probably 4 □ Unknown
-	ord	w requir been si should	ed		. 10	Yes 25 No 3 Probably 4 Onknown
1	ecor	as 2	Completed		24a. Was autoj	psy prior to completion of cause of
13					1 Tes	ormed? death? 2 Mo 1 ☐ Yes 2 ☐ No
~	Vital	ysician: Th is certificate director, pag	Be	examiner?	eath (Check only o	
1	Ψ_	E C -	<u>۲.</u>	1 inpatient 2 EH/Outpatient 3 DOA 4 Unirsing		dence 6 Other (Specify) how injury occurred
2	u o	ding F h. After funera	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?	200. Describe	now injury occurred
J	Division	Vttan deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office	28f. Location /	Street and Number or Rural Route Number.
5.	Div	after Dira Dira	Certification;	4 Homicide building, etc. (Specify)	City or To	
		spits nours naral	-E	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	ce, and due to the	cause(s) and manner as stated.
		na Ho n 24 h na Fu oletely	edic	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occore) and manner stated.	curred at the time,	date and place, and due to the cause(s)
		To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	M	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
		1		1 XIL MD 734652	-	February 25. 2005
		510		30. Name and address of person who completed/cause of death (Item 23a) (Type, Print)	4 . 4	1
	_	<i>y</i>		Scott HOSWILL & North Avinus 1511,	AIF OV	February 25, 2005 Paryland 21014
		Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 1 2005		,

			For State Registrar	State of N	/larylan		artmen rtificat			and M	ental Hy	giene	005	06687
	Physici /Medic		1. Decedent's Name (First, Middle, I Richard	ACD MCD	uff	i'e					2. Date of D Month		Year	3. Time of Death 5.1/2 A.M.
	Examin		4a. Facility Name (If not institution, g Baltimore Rehabili 5. Social Security Number 6	tation Extension	y dod (CAYE last birthday)	4b. City, 3a1 If Under Months	1 Year	Location of Oy Q		8. Date of Bi	rth	County of Deal	thplace (State or Foreign
	Director		242-32-0920 Usual Residence of Decedent	1 X M 2 □ F	78	Yrs.		Days	Hours		08/08/			th Carolina
	he Marylan 28a-1 show	ector	10a. State 10b. County Maryland 10e. Street and Number			y, Town or Lo	nore	0-1-	·			10- Qhi		10d. Inside City Limits 1 ▼ Yes 2 □ No
	with with	ä		root			10f. Zip		,			-	en of What Co	ountry?
36	d within 72 hours after death with the Maryland Jiene. rithen "natural", or Itams 23a or 28a-1 show The Madical Examinatr ust by Indiffed at	by Funeral Director	332 Stinson St 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force	s? 19 □No 10				spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0- 1	S.A. 4. Race - Ame Black, Whit	e, etc.
21215-0036	c 9	Completed t	15. Decedent's (Specify only highest selementary/Secondary (0-12)	Education		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during most	t of worki	ng	16b. Kir	d of Business	/Industry
212	filed within Hygiene. other than "	mo	11	College (1940) J+)	Clea	ning	Tech	nicia	an		C1	eaners	
Maryland	d ta b	Be	17. Father's Name (First, Middle, La Tom McDuffie	st)							(First, Middle		Sumame)	
Ž	should Ind Men	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	na Address	(Street a			illiam		Town, State, 2	Zip Code)
	is 1 and 2 sho of Health and Item 27 is ma other treum		Harrt McDuffie /											and 21244
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	□Removal from Sta	20b. P	Place of Dispo emetery, cre					ate		cation - City or	
ij	Pa anti-		4 ☐Donation 5 ☐ Other (Spe	city)	Gar	rison	Fores	st Ce	me.O	3/09	/2005	Owin	s Mill	s, Maryland
Bal	permit. Departr Importe any inji		21. Signature of Funeral Service L	Sens Car										F/H, P.A. yland 21215
	Pnysician		23a. Part1. Enter the disease, or construction shock, or heart failure. List or immediate Cause (Final disease or condition			- 2			g, such as		r respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. <u>E50</u> Due to (1)	as a con a	uence of):		, –,	103	700				4 grans
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events		as a conseq	uence of):								
8760,	rate be executed thysician and the burial-transit		resulting in death) Last	Due to (or a	as a conseq	uence of):								
O. Box 6	death certific e attending pl id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of del	livery Day Year
<u>a</u>	quires that n signed b uld be deta	by	Part II. Other significant condition	s contributing to death	n but not res	ulting in the u	underlying c	ause give	en in Part I.				1	the cause of death?
I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Wa auto peri 1 Yes	s an opsy ormed? 2 No	24b. Were au prior to death?	utopsy findings available completion of cause of
Vital	sician: T certificat rector, p	Be (25. Was case referred to medical examiner?							of Death	(Check only	one)		
of	ding Phys h. After this funeral di	tion; To	1 Tyes 2 Two 27. Man er of Death 1 Natural 5 Pending 2 Accident investiga			ER/Outpatie 28b. Time of Injury		8c. Injun	4 🗀 Nu		me 5 Res 28d. Describe		Other (Spe	cify)
Division	al or Attanding s after death. Il Diractor: After ad in by the fune	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of	Injury - At ho etc. (Specif	ome, farm, st y)	reet, factory				28f. Location City or To	(Street and own, State)	l Number or Ru	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funarel Dirac completely filled in by	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the be caminer: On the basis and manner	of examina	ition and/or ir	nvestigation	, in my o	pinion, dea	th occurr	ed at the time	, date and	place, and due	to the cause(s)
	To the To the Comp.	Me	29b. Signature and title of certifier	1	1)	'. O	290	License	number	Col	40	29d. Date	signed (Mont	h, Day, Year)
	41		30 Name and address of parson in	no completed cause of	of death (Item	7 &),	Print)	24	22 /	() (,,,,	02	- 27 0	5
	51		John S. Lah M.D.	3900 Loc	4 Rav	en Bou	leva	nd, 1	3alt	mor.	e Max	land	21218	•
	° Sta Regist	ate rar	31. Date filed (Month, Day, Year)	INS Regi	strar's Signa	ature Sol	de	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1		a signed (Mont - 27 C	

			1 - State of Ma		artment of Health and M rtificate of Death		giene Reg. Ne. 005	06688
			Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
	Physici /Medio		John Patrick Magnus			February	/ 26, 2005 Year	9:30AM M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
			6201 Harford Road		Baltimore		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age 159-44-4817 70	(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da December	9. Birthp 17, 1934 Tex	place (State or Foreign
	Director		Usual Residence of Decedent	113.		December	17, 1934 Tex	15
	yend ow			10c. City, Town or Lo			1	0d. Inside City Limits
	Mary F-f sh	to	Maryland N/A	Baltimore				1)∏Yes 2 No
	r 28e	irec	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
	h wit	aj D	6201 Harford Road		21214		USA	
	deet deet	Funeral Director	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No	- 14. Race - Americ	
9	or It	J.	1 ☑ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No		1 ☐ Yes 2 ☑ No Specify:	riidan, otc.)	Black, White, Specify: Wh	ite
21215-0036	filed within 72 hours after deeth with the Marylend Hyglene. ther than "naturel", or Items 23s or 28s-1 show ther than "naturel", or Items 2se routified at ent, I've Medical Exard, we rives be notified at	d by	3 Widowed 4 Divorced Year or Dates:	Techan			Specify. WHI	
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	16b. Kind of Business/In	dustry
12	withi ene. than	m/	Elementary/Secondary (0-12) College (1-4or 5+)	cle Technician		Marine Corp.	
d 2	filed Hygi ther ant, I		17. Father's Name (First, Middle, Last)				Maiden Sumame)	
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Maryler of Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumstic event, I've Medical Examinant must be notified at	To Be	John A. Magnus		Annie Weid	le1		
ary	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rur	al Route Numbe	er, City or Town, State, Zip	Code)
	1 and 2 Heelth a tem 27 li		JoAnn Wilcox Sister	5554 1	Northfield Drive Fort	worth Tex	as 76179	
ore.	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date	20c. Location - City or To	wn, State
Ĕ	Pages nent of I ant: If Its ury or o		1 ☐ Bunar 2 ☑ Cremation 3 ☐ Hemoval from State 1 ☐ Donation 5 ☐ Other (Specify)	Hilltop Ser	rvice Corp. 3/1/0)5	Towson Maryland	i
Baltimore,	permit. Pages 1 and Department of Heelth Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licensee Christina	L. Hilton 22	2. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Bal			
	9.0E # 9		Chustina & Nelton 23a. Part1. Enter the disease, or complications that caused to					
8760,	Physician /Medical Examiner physician and physician and physician and physician and physician sit is physician and physician and physician and physician and physician	ai Examiner	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	consequence of):	Conter			Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	y Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 in the past 12 months? 4 Pregnant at the pre	Fetal death 3 me of death 5	□Ectopic pregnancy □ Other (specify) □ other (specify) nderlying cause given in Part I.	23e. Did to	23d. Date of delive Month	Day Year
rds	tuires n sign	d by				1 DEY	′es 2□No 3□Prob	ably 4 🗍 Unknown
Vital Records,		Completed					rmed? death?	osy findings available npletion of cause of
Ζ	Physiclan: The this certificate all director, pages	Be	25. Was case referred to medical examiner? Hospital:		26. Place of Deat	1.4		
of		. To	1 ☐ Yes 2 ☑ No 1 ☐ Inpatien 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time of	11 3 DOX 4 INDISING HO		lence 6 Other (Specify low injury occurred	')
on	iding I th. After funer	tion	1 Matural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	rear) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	204. 2000.120	ow injury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Cuisido 6 Could not be	/ - At home, farm, str (Specify)		28f. Location (S City or Tow	Street and Number or Rura n, State)	l Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	xamination and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the d red at the time, d	cause(s) and manner as st date and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	N	29c. License number	91	29d. Date signed (Month, I	Day, Year)
•	. 4		1 Jako M		170	14	02/28/	05
	Sta Registr		30. Name and address of person who completed cause of deal of the filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar	greenest	Print) reet 9th Floor	, Winy C	>, Baltinur	e, MA 2120

			For State Registrer	State of Marylan			ealth and	Mental Hy	•	15	06689
	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Last) John Herman 4a. Facility Name (If not institution, give s	Maurer treet and number)		4b. City, Town, or	Location of Dea	2. Date of D Month 2	Day 26 4c. Count	Year CS y of Death	3. Time of Death
	Funeral Director		Baltimore Kehabikt 5. Social Security Number 6. Sex 219-16-4283	5 1 1		Baltim If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year) , 1925		lace (State or Foreign try) cyland
	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e1 show the Model Examiner must be motified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		y, Town or Lo	Essex					0d. Inside City Limits 1 ☐ Yes 2X No
	death with t	Funeral Director	10e. Street and Number 305 Savannah Ro	2. Was Decedent Ever in U	.S. 13. V	10f. Zip Code 21 2 Was Decedent of H f Yes, specify Cuba		Specify Yes or N	10g. Citizen of USA	What Cour	
0000	hours after of urel', or Iter	þ	1 Never Married 2 Married 3X Widowed 4 Divorced	Armed Forces? (X) Yes 2 No If Yes, Give Year or Dates:		l□Yes 2. XXNo	Specify:	rto Rican, etc.)	Speci	White,	9
21215-0036	od within 72 gjene. er than "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done of OO NOT use retired ine Opei	during most of wo ()	orking	Weste:		lectric
Maryiand	should be file of Mental Hy marked oth matic event	To Be (17. Father's Name (First, Middle, Last) John R. Maur 19a. Informant's Name/Relationship (Typ.		19b. Mailir	g Address (Street	Margar	et Gre	SS		Code)
ore, ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By injury or other treumatic event, the Modeal Examiner must be notified at Once.		Ed Morrison /sc 20a. Method of Disposition 1 Spurial 2 Cremation 3 Re	on-in-law	305 Place of Dispo	Savanna sition (Name of natory or other place	ah Road			D 212	221 wn, State
Baltimore,	permit. Pag Department Importent: eny injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Val		Name and Addre	ss of Facility		Funera	lHome	MD eofEssex
	nysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the deat a cause on each line. Due to (or as a consequence)	tra	er the mode of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	death certificate be executed we eattending physicien and word for use as the burial-transit under the control of the control	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t							
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3□	Ectopic pregnancy Other (specify)	,			ate of delive	ery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		tobacco use cor Yes 2 No		ne cause of death?
al Records,	The ate his page	Completed						peri 1 ☐ Yes	ormed/ 2 No	prior to cor death?	psy findings available inpletion of cause of 2 No
ion of Vital	ng Phys ter this neral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Vinpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing	eath (Check only Home 5 Res 28d. Describe			v)
Division	itel or Attendir urs after death. iral Director: Al lled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy)			City or To	(Street and Num own, State)		
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 ▼ Certifying Phys 2 ■ Medical Exeminate Physics (Check only one)	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tir vestigation, in my o	pinion, death occ	ce, and due to the curred at the time	, date and place	, and due to	the cause(s)
	- 1	-	30. Nam and address of person who co	impleted cause of death (Ital	n 23a) (Typa			(+10)	29d. Date sign		
	Sta Regist		John S' Lah MD.	mpleted cause of death (Iter 3900 / 00 / R 32. Register's Sign:	aven C	Boulevar	d Belg	timore,	narylan	121	2/8

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			For State Registrar	State of Maryla	nd / Depa			Mental Hyg	6-	005	06690
				1	Cei	lilicale of	Dealli	2. Date of Dea	eg. No.		2 Time of Death
	Physicia		 Decedent's Name (First, Middle, Last, 					Month	Day	Year	3. Time of Death
	/Medic	al	Larry Robe		3			Februar			
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	th	1	County of Dea	
			619 Chapelgate Dr	ive			nton If Under 24 Hrs	J		Anne A	
	Funeral		5. Social Security Number 6. Security Number 1.	VM 2□F	i. last birthday). Yrs.	Months Days	Hours Min	. (Month, Day	, Year)		thplace (State or Foreign ountry)
	Director	-	308-48-5466 Usual Residence of Decedent	58				Aug. 18	, 19	146 T	exas
	and and		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	f she	5	Maryland Anne Aru	nde1	0dent	ton					1 XYes 2 ☐ No
	the 28a-	ecl	10e. Street and Number			10f. Zip Code		1	t0a. Citiz	en of What Co	ountry?
	with se or	<u> </u>						'			
	eath	by Funeral Director	619 Chapelgate Dr	12. Was Decedent Ever in	U.S. 13 V		1113	Specify Ves or No-		ited S	
	lter d	Š	1 Never Married 2 Married	Armed Forces?	10.1	f Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- to Rican, etc.)	,	Black, Whi	
99	rs af	by	3 Widowed 4 Divorced	1 TYes 2 □ No If Yes, Give Year or Dates: 1964	70	1☐ Yes 🏞 No	Specify:			Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show The Mayleal Exactiner must be notified at	ed	15. Decedent's Edu			ient's Usual Occur	pation		16b. Kin	d of Business	/Industry
<u>7</u>	in 72	plet	(Specify only highest grad	le completed)	(Give		during most of wo	orking			·····dadiiy
7	with lene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	E1	ngineer			App1	ied Si	gnal Tech.
0	should be filed within 72 hours after death with the Marylan of Mental Hygiens, marked other than "natural", or flems 23a or 28a-f show marked other than "natural", or flems 23a or 28a-f show marked other than "natural".		17. Father's Name (First, Middle, Last)			ISTHEET	18. Mother's Na	me (First, Middle,	Maiden S	Sumame)	
an	d be antal	To Be	La Vern A	. Minnis			Neta	Mae	T _a)	la11	
2	mar mar	1	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street		ural Route Numbe			Zip Code)
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is markad any injury or other traumatic es once.		Linda M. Minnis/W			Chapelga		Odenton			
a,	1 an Heal am 2		20a. Method of Disposition			sition (Name of natory or other pla		Date		ation - City or	
Baltimore,	nt of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	TOTTO VALE				- /		•	
틆	rtme rtant njury	r	* 4 □ Donation S □ Other (Specify) 21. Sign there of Funeral Service Licens				ory 2/2!				aryland
Bal	Departiment of the particular							Home & C			
	202 4 4							ad Odent		Maryla	
-			23a. Parth Enter the disease, or composhock, or heart failure. List only o	ne cause on each line.	atn. Do not enti	er the mode or dyl	ng, such as cardia	ic or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Pulmonary	Emboli:	sm					Onder and Dough
	/Medical Examiner		resulting in death)	Due to (or as a conse							
	Lxammer	_		bCardiomyor	oathy						
	e ii	Examiner	cause. Enter Underlying	Due to (or as a sones	iquante of):						
	acute tnd trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c							
ő	ate be executed hysician and the burial-transit		rossiming in occarry seast	Due to (or as a conse	equence of):						
8760,	cate b ohysic the b	licai		d							
9	death certifica e attending phi d for use as th	Med	IF FEMALE:							7.0	
Вох	leath certific attending p	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnanc	:y		2:	3d. Date of de	
		sici	in the past 12 months? 1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5	Other (specify) _			į	Month	Day Year
P.0	at the de by the a	Physician/M	9 🗆 Unknown								
	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co	entributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.				o the cause of death?
Records,	w require been si should b		Diabetes					1 🗆 Y	es 2🏻	No 3□P	robably 4 Unknown
00	faw requas been 2 shoul	Completed	Hypertension					24a. Was a		24b. Were a	utopsy findings available
æ	The I	Eo						autop: perfor 1X Yes	med?	death?	completion of cause of
Vital		e C	25. Was case referred to medical				26. Place of De	ath (Check only or		12010	2 2 1 1 1 1 0
5	Physician: this certific al director,	OB	ayaminar?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	nt 3□ DOA Ot		Home 5 X Resid		Other (Soc	aciful
of		ı:	27. Manner of Death	28a. Date of Injury	28b. Time of	f 28c. Inju	ry at	28d. Describe h			outy/
on	ding I h. After funer	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2□No				
S	≥ ± ∞	(0	3 ☐ Suicide 6 ☐ Could not be	286. Place of Injury - At	home, farm, str	eet, factory, office		28f. Location (S	treet and	Number or R	ural Route Number,
	an eat or:	ŭ		building, etc. (Spec	oify)			City or Tow	n, State)		
Division	or Attanter deat iractor:	ertific	4 Homicide determined					1			
Ο̈́	or Attanter deat iractor:	al Certification;	4 C Horniciae	/sician: To the best of my ki	nowledge, deati	h occurred at the t	ime, date and place	e, and due to the c	ause(s):	and manner a:	s stated
Div	or Attanter deat iractor:		29a. Certifier 1 X Certifying Phy	ysician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deati nation and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the durred at the time, of	ause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
Div	or Attanter deat iractor:	Medical Certific	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exem	iner: On the basis of exami	nowledge, deati nation and/or in	h occurred at the t vestigation, in my 29c. Licen	opinion, death occ	urred at the time, o	date and	place, and du	s stated. e to the cause(s) th, Day, Year)
Div	or Attan after deat Diractor: in by the	edicai	29a. Certifier 1 Certifying Phyone) 2 Medicel Exem	iner: On the basis of exami	nowledge, deatination and/or in	29c. Licen	opinion, death occ se number	urred at the time, o	late and	place, and du	th, Day, Year)
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FEBRUARY

JESSIE

Saminer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De	City Limits es 2 No
Medical Examiner A. Facility Name (if not institution, give atreet and number) A. County of Death A. Count	e or Foreign City Limits es 2 No
S. Social Security Number S. Sex T. Age (In yrs. last birthday) Il Under I year Il Under 24 Hrs. S. Date of Birth Day Year T. Age (In yrs. last birthday) Il Under 1 year Il Under 24 Hrs. S. Date of Birth Day Year Day Sex Day Year Day Sex Day Year Day Day Year Day	City Limits es 2 No
S. Social Security Number G. Sex T. Age (In yrs. last birthday) H. Under 1 Yes. H. Under 2 Hrs. H. Under 2 H	City Limits es 2 No
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21. Signature of Fundral Service Licenses 22. Name and Address of Facility 23a. Part. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of):	+34
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Cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Weditional ing phy ing	
23d. Date of delivery in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of yes 2 No 9 Unknown 25e	of death?
S S S S S S S S S S S S S S S S S S S	□Unknown
Yes 2 No 3 Probably 4 C 24a. Was an autopsy, performac? 1 Yes 2 No 1 Yes 2 N	s available cause of
25. Was case referred to medical examiner? 1	
27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28	
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28d. Describe how injury	ımber,
29a. Certifier (Check only) 29a. Certifier (Check only) 29a. Certifier (Check only) 29a. Certifier (Check only) 29a. Certifier (Check only) 29a. Certifier (Check only)	∋(s)
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Mount folder William 001730 February 20, 2	2005
State Registrar MAR 0 1 2005 MARVINI J. FELDMAN MO Baltimore, Md Z1202 32. Flistrar's Signature MAR 0 1 2005	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** February 27, Bernice Kathryn Mahla 2005 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2X F Yrs 76 220-24-6312 Director Pennsylvania MAR 5, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28a-f show any highry or other traumatic event. The Medical Examination and once. 1 Yes 2 □ No Directo Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2017 Harman Avenue USA 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration 12 Scout 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thearl Clifton McKonly 2 <u>Margaret Marie Breighner</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2055 Grinnalds Avenue Baltimore, MD 21230 George H. Mahla/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. ` 4 ☐ Donation ¹⁵ ☐ Other (Specify) 2/28/05 Baltimore, MD 21. Signature of Funeral Septice Licensee Edward A Cregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEART CONGESTIVE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) _ Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics 1 ☐ Yes 2 No 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIE MAHMOOD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

DHMH 17 Rev 1/2001

FEBRUAR

BEANICE

2300_

32. Registra Signature

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29c. License number

29d. Date signed (Month, Day, Year)

VALLEY AD, TIMONIUM, MD 21093

			State of Maryland / Department of Health and			
			1- State Registrar Certificate of Death		No.2005 061	694
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	Death
	Physici /Medic		Jeanne Thompson McLean	FEBRUAR		^M q0
7	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of Death	-
			Corsica Hills Center Centreville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F	Hrs. 8. Date of Birth	Queen Anne's	as Familia
п	Funeral Director			March 10,		ar Foreign
	D D		Usual Residence of Decedent	PAICH IU,		
	arylar show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside C	ity Limits 2 ₩ No
	the M	ecto	Maryland Harford Fallston 10e. Street and Number 10f. Zip Code	100	Citizen of What Country?	
	with 1	Dir	312 Old Joppa Road 21047	109.		
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9	or Ite	/ Fur	1 Never Married 2 Married 1 Yes 2 No	ierto Hican, etc.)	Black, White, etc.	
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Maryland	2 sho		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or</i> 19c. 19d. Joppa Rd., I			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place)		Location - City or Town, State	
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ä	permit. Departr Importr any inj		1317 Cokesbury Roa		n, Maryland 210	009
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П			313 West Pasade	na Road			Mi11					Anr		unde1	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last		If Under	1 Year Days	If Under a	24 Hrs. 8. (Date of Birth Month, Day, y 27,	Year)	9. Birthp Cour MD	place (State or ntry)	· Foreign
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	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	10d. Inside Cit	y Limits
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	ns 2;	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Deced	ent of Hi	spanic Orig	gin? (Specify n, Puerto Rica	Yes or No-			can Indian,	
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N	filed w Hygier other tl		17. Father's Name (First, Middle,	2		Techi	nology	y Mai				laiden Suman		Gaillote	
and	be fill	Be		Lasi						,			,,,		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Helen J. Mulhearn 10:20 AM February 27, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 115 Quincy Street Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F 84 Director 162-18-8721 Yrs July 29, 1920 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "neturel", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 X Yes 2 No Maryland Montgomery Chevy Chase Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 115 Quincy Street 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States College (1-4or 5+) 2. Elementary/Secondary (0-12) Chief of Visa Office Department of State and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H lent: If item 27 is marked ot Saverio Funaro Rosina Mele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Barry Mulhearn/Son 1802 North Pine St., Lumberton, North Carolina 28358 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 4, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Robinson Township, permit. Page Department of Importent: If any injury or once. Holy Souls Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Pennsylvania 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Ervor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Emphysema **Physician** Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2**X** No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To To the Hospitel or Attending Ph within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title titier 29c. License number 29d. Date signed (Month, Day, Year) D42057 February 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Scott Cohen, M.D. 5530 Wisconsin Avenue #930, Chevy Chase, Maryland 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 1 2005 WELLES. Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 20, 2005 1643 Florence Williams Martino /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Dec . 28, 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2X F 82 Yrs. 246-28-1878 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1XYes 2 No Directo Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 238 1208 Thornden Road 20851 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or item
any injury or other traumatic event, the Wedical Eventuer 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Cryptographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Souther Charles W. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer C. Martino/Husband 1208 Thornden Road, Rockville, Maryland 20851 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State March 9. Arlington National
Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 Arlington, Virginia ¹ 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Fungral Service Licensee MO1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Mas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent oregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Vinpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct 4 Homicide cai 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) he and address of person who completed cause of death (Item 23a) (Type, Pri 9901 Medical Center Drive 112 LOV Rockville, Maryland 20850 32. Ringistrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar

State of Maryland / Department of Health and Mental Hygierje Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:20 P M Florence H. Mohr February 25. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Potomac Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 ☐ M 2 💢 F 95 Director 10, 1909 154-28-6353 Nov. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 4300 Massachusetts Ave. N.W. Funeral 20016 death United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. snt: If Item 27 is marked other then "natural; or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emil Christian Hildebrand Mary Ann Poempner ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Mohr Donovan/Daughter 4300 Massachusetts Ave., N.W., Washin ton, DC 20016 20b. Place of Disposition (Name of comptent, crematory or other place)
Montgomery
Crematorium, Inc. Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Importent: If ite
any injury or of February 28, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Bethesda, Maryland Fumphrey Funeral Home/ 2. 7557 Wisconsin Avenue Bethesda-Chevy Chase, Inc. M01346 Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Advance di resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ŏ in the past 12 moeths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Atricel 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? page certificate 1 ☐ Yes 2 □No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the f 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 26/05 10054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sucidua Bhogavilei 1220 A fait ToppaRoad Sceit 230, Towson, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 06699 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 24, 2005 **Physician** ESTHER K. OLNEY 8:35 а.м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner OAK CREST CARE CENTER BALTIMORE PARKVILLE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ XF 83 Yrs. Director 6/16/1921 PENNSYLVANIA 166-18-7815 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County BALTIMORE PARKVILLE 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8834 WALTHER BLVD. 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced "naturel", WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumetic event, Ille Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within intent of Health and Mental Hygiene. Int: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNAVAILABLE AMELIA OSMAN ္က 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau GLENN OLNEY/SON 190 FRINGE TREE DRIVE WEST CHESTER, PA 19380 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State rematory or other place)
VALLEY MEM
GARDENS DULANEY 2/28/2005 COCKEYSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JCHNSON FUNERAL HOME, F.A. 21. Signatur of Funeral Servi≰e Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosdendic cardiovascular **Physician** 4COUR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ with Maletrio 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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			For	State of Marylan				lental Hyg	iene	06700
			State Registrer		Cer	tificate of L	Death	2. Date of Deat	eg. No. UUJ	U D / U U
	Physici		1. Decedent's Name (First, Middle, La John P. O'Hara	st/				Month	Day Yea	M
	/Medic		4a. Fecility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of Death	February	4c. County of De	3:00 A
			Washington Adversion 5. Social Security Number 6.5	itist Harn		Takoma F			Montgome	ru
	uneral		5. Social Security Number 6. 9 6. 9	Sex 7. Age (In yrs. 1 1 ✓ M 2 □ F 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	inthplace (State or Foreign Country)
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ırylanı	wow		10a. State 10b. County MD Anno An		y, Town or Lo	cation				10d. Inside City Limits
he Ma	88-f.s	ecto	1	undel Laur	el	1404 71 0.4			0-02	1 ☐ Yes 2 💆 No
with t	la or	Funeral Director	10e. Street and Number 3374 Crumpton St			10f. Zip Code			0g. Citizen of What (Country?
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after	or Ite	y Fu	1 Never Married 2 Married	If Yes. Give		Tes, specify Cuba I ☐ Yes 2√ No	Specify:	ricari, etc./	Black, Wh	
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though	mark	2	John P. O'Hara 19a Informant's Name/Relationship	(Type, Print)	19b. Mailin	a Address (Street a	Catheriy	16 Colon	; City or Town, State	Zip Code)
nd 2 s	27 ls r trau		Terrance O'Hara	/Son					724 20c. Location - City o	
es 1 a	Department of result and wenter register. Department of result and wenter register. By injury or other traumatic event, It a Modical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Permoval from State	lace of Dispo emetery, cren	sition (Name of natory or other place	e)	Date	20c. Location - City of	or Town, State
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UNISION or Attending	arrer deatn. Director: Al I in by the fu	ifica	3 Suicide 6 Could not I	28e. Place of Injury - At ho	me, farm, str				reet and Number or F	Ru <i>ral R</i> oute Number,
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15.	+1		30. Name and address of person who				1 ORK	KNBEL		U#3
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			1 - For State Registrar	State of Maryla	and / Depa	artment of F rtificate of	lealth and M Death	ental Hygier		06701
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	Examin Funeral Director	er	201 22 0700	E CRESCENT C	ITIES ers. last birthday) Yrs.	4b. City, Town, of HYATTS If Under 1 Year Months Days			4c. County of Deat RINCE GEO ar) 9. Birtl Co 1924 VI	
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5-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if e Medical Examination resulting an once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	943- 46	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: WH	rican Indian, e, etc. ITTE
Maryland 21215-0	within 72 ho ene. than "natu	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired DRIVER	during most of working	ng	Kind of Business/	
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Mar	12 sho h and 7 is ma trauma	3	19a. Informant's Name/Relationship (7	ype, Print)	1	(E)	and Number or Rural ON ST. HYA			
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	Sta Registr	-	31. Date filed (Month, Day, Year)	32/Registrar's Si	gnature	wie	··· · • • • • • • • • • • • • • • • • •	, 1410 LV/01		
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			For State	State of Maryland /		t of Health and le of Death		2000	06702
			Registrar 1. Decedent's Name (First, Middle, Las	1)	Certificat	e or beaut	2. Date of De		3. Time of Death
	Physicia		Tryin	. Parker			Month FEBRUA	Day Year RY 23, 200	1.4
	/Medic Examin		4a. Facility Name (If not institution, give			Town, or Location of Deat		4c. County of De	
И			3605 FAIRVIEW AVI			TIMORE CITY	100 (0)	NC	
	Funeral Director		012-60-1113	M 2□F 7. Age (In yrs. last b	Yrs. Months	1 Year If Under 24 Hrs Days Hours Min.	8. Date of Bir	ay, Year) 9. B	irthplace (State or Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	d within 72 hours after death with the Maryland plene. Than "natural", or Items 23a or 28a-f show the Medical Examination notified at	Director	MD IVIC	i B	altin	lore			1 des 2 □ No
	with the	Dire	10e. Street and Number	A	10f. Zip	Code		10g. Citizen of What 0	Country?
	ns 23	Funeral	3 605 FUL	12 Was Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	pecify Yes or No	14. Race - An	
٥	after or Item		1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 M No If Yes, Give	If Yes, spe	1	to Hican, etc.)	Specify: T	nite, etc.
5-0036	hours ural',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	a. Decedent's Usu			16b. Kind of Busines	SIACK
7	n nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give kind of wo	irk done during most of wo	rking	100. Killa di Basilles	sindustry
212	TO 100 100 100 100 100 100 100 100 100 10	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Secur	ity offi	cer	5 5	5 A
land	be filed ital Hygi id other event, L	Be	17. Father's Name (First, Middle, Last)	2. 1		18. Mother's Na	me (First, Middle	, Maiden Sumame)	
		2	19a, Informant's Name/Relationship (Jacker Line	Dh. Mailing Address	(Street and Number or Ri	e I Cu	Lewis	Zin Code)
Mary	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Mrs Kalle Lee	1 Due Vac	3701	Ferndale	Ave	Raito M	D 031207
ē,	es 1 ar of Hea of Hea fitem		20a. Method of Disposition	comot	of Disposition (Nation), crematory or o	me of	Date	20c. Location - City of	
altimore,	Pages ment of ant: If it ury or o		1	Hemoval from State	aine Pa	2013/	2/05	Baltim	ore, MD
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service kicen	500	22 Name ar	nd Address of Facility	Fringro	~ 11'	P.A.
	40240		23a. Part 1. Enter the disease, or comp	plications that caused the death. Do	o not enter the mod	de of dving, such as cardia	c or respiratory a	e Balto,	MD Q1216 Approximate
	Physician		shock, or heart failure. List only inmediate Cause (Final	one cause on each line. ARTERIOSCLEROT					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. ARTERTOSCLEROT		VASCULAR DIS	EASE		
	Examiner		Sequentially list conditions,	b	0				
	ted 1.sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				
<u>,</u>	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence	e of);				
8760	The law requires that the death certificate be executed the bas been signed by the attending physician and page 2 should be detached for use as the burial-transitions.	dlcal	(d					
39 ×	entifica ding ph	Med	IF FEMALE:	23c. If yes, outcome of pregnancy					
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death	th 3 ⊟Ectopic p 5 ⊟ Other (s			23d. Date of d Month	elivery Day Year
P.O.	that the de led by the a detached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown					
S,	igned be det	by P	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying o	cause given in Part I.	1	tobacco use contribute	
Records,	w require been sig should t	eted							Probably 4 Winknown
Rec	has t	Completed					24a. Was auto perfe	psy prior to ormed? death?	
g		Be Cc	25. Was case referred to medical			26. Place of De	1 ☐ Yes ath (Check only		es 2 No
<u>=</u>	Physicia this cer ral direct	To B	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 De	OA Other: 4 Nursing H	Home 5 Res	idence 6X1Other (Sp	pecity) SCENE
0	ding Pt h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	(Month, Day Year)		28c. Injury at Work?	28d. Describe	how injury occurred	
Division of Vital	or Attending Physician: after death. Director: After this certifica in by the funeral director, I	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		farm, street, factor	1 Yes 2 No	28f. Location	Street and Number or i	Rural Route Number,
<u>></u>	tal or A	Certification:	4 Homicide determined	building, etc. (Specify)		,,	City or To	wn, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ysician: To the best of my knowled niner: On the basis of examination a and manner stated.					
	To the To the comple	Me	29b. Signature and title of certifier		29	c. License number		29d. Date signed (Mo.	nth, Day, Year)
	1 10		Jasher	reenhen Ku	Q.	OCME		FEBRUARY 25	,2005
j	1700		30. Name and address of person who		a) (Type, Print)	11 Penn Stre	et Balt	imore. Mar	vland 21201
~	Sta	rte.	TASHA Z.GREENBERG 31. Date filed (Month, Day, Year)	32. Regulari's Signature					<i>J</i>
34	Regist		MAR 0.1	2005 Maria	G DOWN				

DHMH 17 Rev 1/2001

			For State Registrar	State of	f Marylan		rtment of F tificate of	lealth and M <i>Death</i>	-	giene Reg. No. () (15	06703
۱	Physicia	an	Decedent's Name (First, Middle, Las ROSEALMA RODERI		,				2. Date of De Month FEBRUA	Day .	Year 2005	3. Time of Death 10: 16 A.M
	/Medic Examin		4a. Facility Name (If not institution, give				•	r Location of Death	1 DDITO	4c. County	of Death	
	Funeral		8820 WALTHER BLV 5. Social Security Number 6. Secu	ex	7. Age (In yrs.	ast birthday)	PARKV	If Under 24 Hrs.	8. Date of Bir	th	IMORE 9. Birtho	place (State or Foreign
	Director		538-22-1810 ¹ Usual Residence of Decedent	□ M 2 ② F	80	Yrs.	Months Days	Hours Min.	4/21/1	924	WAS	HINGTON
	anyland show	_	10a. State 10b. County			, Town or Lo			VO-2		1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	the Mark	Director	MD BALTIMO 10e. Street and Number	RE	PA	RKVILL	日 10f. Zip Code			10g. Citizen of	What Cour	
	ath with		8820 WALTHER BLV				2123			USA		
036	77 hours after death with the Marylan "natural", or Items 23e or 28e-f show edical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 🕅 No 'e	l II	Vas Decedent of Pi Yes, specify Cub	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Specif	ce - Americ ck, White,	
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23e or 28a-f show with the Medical Examinat must be notified at	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1	-4or 5+)	(Give I life. L	ent's Usual Occup kind of work done OO NOT use retire MAKER	during most of work	ing	16b. Kind of B		dustry
	at Hygie I other I	Be Co	12TH GRADE 17. Father's Name (First, Middle, Last)			1101111	PHILIT	18. Mother's Name		Maiden Suman		
Maryland	2 should be and Mental is marked o	<u>0</u>	JOHN P. OWENS 19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	OLIVI and Number or Rura	NE MALL		State, Zip	Code)
	and 2 Balth a n 27 is		STEVEN RODERICK/		1001	1092	4 HARMEL	DRIVE C	OLUMBIA	, MD 2	1044	
altimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	1)	State	emetery, cren 'RO CRE	sition (Name of natory or other place MATORY,	INC. 2/2	8/2005		VILLE	, MD
Ba	permit. Departr Importe any inju		21. Sign turn of Funeral Service Licen	U. Hu	if		Name and Addre	RAVEN BLV.			RAL H 2128	IOME, P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	olications that cone cause on e						rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	or as a conseq		47C	ma				
ı	Examiner	er	Sequentially list conditions,	b. Due to (or as a conseq	uence of						
	and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	or as a conseq							
8760,	cate be executed physician and the burial-transit	dical E		. d	or as a consequ	uerice oi).						
9			IF FEMALE:	23c. If yes, out	come of pregna	ncv				22d Do	te of delive	.n.
.O. Box	the death certifi y the attending ached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live b	inth 2 ☐ Feta ant at time of d	death 3	Ectopic pregnance Other (specify)	/		1	onth	Day Year
rds, P	The law requires that the de ate has been signed by the a bage 2 should be detached t	by	Part II. Other significant conditions of	entributing to de	eath but not res	alting in the ur	nderlying cause giv	ren in Part I.	23e. Did to			ne cause of death?
Records,		Completed							24a. Was autop perfo 1 Yes	rmed?	Were auto prior to cor death?	psy findings available mpletion of cause of 2 No
Vital	Physician: Th r this certificate ral director, paç	o Be (25. Was case referred to edical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Ott	26. Place of Deatl	/	dence 6 □Oth	er (Snecifi	v)
n of	a + P	\vdash	27. Mann of Death 1 Matural 5 ☐ Pending	28a. Date (Mon		28b. Time of Injury	28c. Injur	y at rk?		how injury occur		,,
Division of	• Hospital or Attendin 24 hours after death. • Funerel Director: Att etely filled in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place	of Injury - At ho ng, etc. (Specif	ome, farm, stre	M 1 □	Yes 2 □ No	28f. Location (S City or Tov	Street and Numb vn, State)	oer or Rura	I Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exen	niner: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tile restigation, in my o	me, date and place, ppinion, death occurr	and due to the red at the time,	cause(s) and ma date and place,	anner as st	tated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	F2(1	1	29c. Licens	242H	2 :	29d. Date signe	d (Month,	Day, Year)
	17)		Bruce Bluncath	of M	se of death (Item	00 Wa	elhu	Bld ;	Parlowi	ea in	8 5	21234
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1	2005	egyfrar's Signa	ture J.	Sporte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item//c,10b,perMD.FH.38/2,4/26/05 TT State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar 06706 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February27, Betty Jane 2005 11:10 p.M /Medical 4c. County of Death Co. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Monkton Baltimore 3606 Lord Baltimore Way If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 79 Director 216-24-8290 3, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mentat Hygiene. Int: If item 27 Ia marked othar than "natural", or Itams 23a or 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits 10a State Harford Co. "natural", or Itams 23a or 28a-f ahow dical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Co. Maryland Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3606 Lord Baltimore Wav 21111 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. Completed by White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic avant. It e Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mercy High School Office Manager 12 yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Wright ဂ Nelson E. McClure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3606 Lord Baltimore Way Monkton, MD 21111 Mr. Glenn M. Parr / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Lepartment of Important: If it 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ! 3-04-2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee Scott P. Gardner 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit the attending physician Physician/Medical as the b IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 5 Other (specify) 4□Pregnant at time of death detached à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? Yes 2 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending death. 2 🗆 No investigation Accident within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/200

State

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Box 68760.

P.O. |

Division of Vital Records,

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 22 2000 (h /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner runde OPEN 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 216-64-1054 Director April 19, 1959 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. In the Maryland the Maryland the Maryland the Maryland the Maryland the Maryland the Maryland the Maryland the Maryland the Indianal the Indianal the Indianal the Indianal the Indianal the Indianal the Indianal Maryland the Maryland M 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 □ No Director Maryland | Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1925 Militia Lane 21113 Completed by Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Logistics NASA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ James Henry Pepin Mary Ann Tanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Nicole Pepin/daughter 1925 Militia Lane Odenton, Maryland 21113 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If its eny Injury or o 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 2/24/05 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Thomas ianila M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a conseq Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? cate has been sig page 2 should b 24a. Was an autopsy performed? certificate has 2 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 № Yes 2 □ No edical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 NER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident illed in by the Diractor: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ۵ leter cause of death (Item 23a) (Type, Print) ne and address of person who com 109 Owe mD Registrar's Signature State Registrar

			1 - State State Registrar	of Maryland		artment of Healtl <i>rtificate of Dea</i>		Hygier Reg. i	4000	06706
	Physicia		1. Decedent's Name (First, Middle, Last) Oriel P. Pearman				2. Date Febru		23, 2ď05	3. Time of Death 11:50PM
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and not Carroll County General 5. Social Security Number 156-14-2454 6. Sex			Westminst If Under 1 Year If Under 1 Year Hou	er	of Birth	Carroll ar) 914 Ber	place (State or Foreign ntry) muda
	pu 🔭		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or L	ocation				10d. Inside City Limits
	Maryla 1 shot	jo	Maryland Baltimore		wynn					1 ☐ Yes 27 No
	n 28a	Director	10e. Street and Number		WYIIII	10f. Zip Code		10g.	Citizen of What Cou	ntry?
	ath wit	ralD	4010 Buckingham Road			21207			USA	
5-0036	y within 72 hours after death with the Maryland piene. r than "natural", or Items 23e or 28e-1 show Itte Medical Ezantitur rust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dec		. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 XNo Spec		or No- :.)	14. Race - Ameri Black, White, Specify: Bla	etc.
ဂ ဂ	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed,)	16a. Dece (Give	dent's Usual Occupation kind of work done during r DO NOT use retired)	most of working	16b.	. Kind of Business/Ir	dustry
121	within iene. than "r	omp	Elementary/Secondary (0-12) College ((1-4or 5+)	~	etary		St	ate Gover	nment
מ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. M	other's Name (First, M			
Maryland		2	Kenneth Pearman		40: 14:33		Lesselene			
<u> </u>	d 2 s th ar 7 Is treu		19a. Informant's Name/Relationship (Type, Print) Dwight A. Pearman, Neph.	ew f		ng Address <i>(Street and Nui</i> Downing Beacl				
Se,	of Hei		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from	20b. Plac	ce of Disponetery, cre	osition (Name of matory or other place)	Date		Location - City or T	
Baltimore,	Pages tment of tent; If it iury or o		` 4 ☐ Donation 5 ☐ Other (Specify)	Metr		ematory Inc.			ltimore,	
Ra	permit. Page Department of Importent; if any injury or		21. Signature of Funeral Scried Insee		<u>Ĉ</u>	2. Name and Address of Fa remation Soc 99 Frederick	iety Of Mai Road Balt:	yland Imore	d Inc. , Marylan	d 21228
68760,	Medical Examiner of the private of t	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents.	or as a conseque	ence of):	Respirations		L TW	e	Approximate Interval Between Onset and Death
C. Box	death certif e attending d for use as	Physician/Me	in the past 12 months?	utcome of pregnance birth 2 Fetal d nant at time of dea nown	leath 3[□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
rds, F	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to d	death but not resulti		inderlying cause given in Pa		Did tobacc 1 □ Yes	o use contribute to t 2 ☐ No 3 ☐ Prof	he cause of death?
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<u> </u>	sician: certific irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 10		2/0 /	Othor	lace of Death (Check of		.50.	
10	g Physical diseased d	 	27. Manner of Death 28a. Date	Depatient 2 ☐ Eff of Injury onth, Day Year)	8b. Time o	nt 3 DOA 4L	Nursing Home 5 28d. Desc		ijury occurred	y)
SIO	eath. or: Aft	catlo	1 Natural 5 Pending (Moi 2 Accident investigation 3 Suicide 6 Could not be	in, bay roar	n jury	M 1 Yes 2				
UIVISION	I or Att	ertification;	determined 28e. Plac	e of Injury - At hom ling, etc. (Specify)	10, farm, st	reet, factory, office		on (Street r Town, Sta	and Number or Rura ate)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the I and ma:	e best of my knowle basis of examination oner stated.	ledge, deat	th occurred at the time, date ivestigation, in my opinion,	e and place, and due to death occurred at the t	the cause ime, date a	e(s) and manner as s and place, and due t	stated. the cause(s)
	To th within To th comp	Me	29b. Signature and the of certifier	200		29c. License numb			Date signed (Month,	
	\cap		Therewich	, INI. D	٠. د	10-00	54218	02	4-24-	05
	0		30. Name and address of person who completed cau	se of death (Item 2 a heug.	349 349	Malcalm a	dun, we	, fmi	WHY MD	2/157
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** illian February 1:30 AM 2 005 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview
5. Social Security Number Baltimore
If Under 1 Year | If Under 24 Hrs. Medical enter 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 257 Yrs. Director July 14,1922 Maryland 82 215-14-4488 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 21224 United States 7518 Riddle Avenue Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "neturel", or Items 23. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own- Home 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Alvater George Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If Item 27 is
any injury or other treu Baltimore, Maryland 21224 Charles Riggen / Husband 7518 Riddle Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 2/26/2005 Baltimore, Maryland 21. Signature of Funeral Service Licepage 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 11. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Ischenic Stroke 12 hours resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Month Day Year 5 Cher (specify) signed by the at the detached for 4☐Pregnant at time of death Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of 29c. License number MD RES-000 February 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Jordan MDPLD, John Hopkins Bryview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224 31. Date filed (Month, Day) 2095 Registra Jajonature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1- Stee Registrar AMEND ITEM #18 PER FH C841 3/01/163te_of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day . ENVES FEBRUTARY **Physician** 3:51A Charles Hoshall Rahe /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Sept. | 30 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Sept. Director 213-10-4250 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Cockeysville Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21030 USA items 23a 13801 York Rd. Apt. A5 Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2√☐No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: If Yes, Give Year or Dates: Specify: white à **X**□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer PA Power & Light JENNTE Name (Fire Widdla Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle J. Hoshall ပ္ Herman W. Rahe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trat QDCE. Charles Hoshall Rahe II/Son 2025 Stone Mill Rd., Lancaster, PA 17603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 5 Dother (Specify) Parkville, MD 3/1/05 ¹ 4 □ Donation Parkwood Cemetery 21. Signature of ta 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOGENIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine requires that the death certificate be executed the burial-transit CORDNARY ARTERY DISEASE Due to (or as a consequence of): attending physician Box 68760 lan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Physici P.O. P the 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe MITRAL REGURGITATION 1 Yes 2 X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an Was an autopsy performed?
Yes 2 No has page 2 certificate 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only on examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending death. 1 Tes 2 No investigation within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only onel the 29d. Dale signed (Month, Day Year) 29b. Signature and title of 29c. License number D 24034 30. Name and address of person - o completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 76/21 TOWSON MARYLAND 21204 LOW M. TIMOTHY 31. Date filed (Month, Day, Year) MAR 0 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. U 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rilev February 26, 2005 7:45 A Gerber Kathleen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Cockeysville Baltimore Broadmead 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Yrs. 91 Jan 1, 1914 Virginia 218-32-9764 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23s or 28s-f show the Medical Exerciner must be notified at 1 ☐ Yes 2 No Directo Cockeysville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13801 York Road 21030 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Community Activism 11 n/a Community Activist 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, since. 17. Father's Name (First, Middle, Last) Be Landis Ada Florence DeVan Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2105 Tufton Ave., Reisterstown, Maryland 21136 William Edward Gerber/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 13/2/05 Sparks, Maryland Jessops Cemetery Bryan W Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. Va 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that used shock, or heart failure. List only one cause on a chilir Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, used Immediate C use (Findisease or condition resulting in deat II **Physician** /Medical Due to (or as a consequence of) 1 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) 68760. Physician/Medical use as Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) o. مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 12 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? STIVE 24a. Was an has autopsy performed? ebed 2 HNo 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 / ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural Division 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by within 24 hours a To the Funerel C 1 E-ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the ! 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature RO 31. Date filed (Month, Day, Year) 2005 Registrar

			1 - For Stata Registrer	State of M	aryland / Do	epartmen Certificate			Mental Hy	giene Reg. No. () {	050	6710
	Physici		1. Decedent's Name (First, Middle, Las Howard W. Russe	,					2. Date of De Month Februar	Day	Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give)	4b. City,	Town, or Lo	ocation of De		4c. County		6:03 A. [™]
			Calvert Memoria	1 Hospita	1			Frede			vert	
	Funeral Director		5. Social Security Number 6. S 027-14-5210 Usual Residence of Decedent	ex 7. Ag	ge (In yrs. last birth 82 Yı	Months		f Under 24 H Hours Mi	n. (Month, Da	rth ay, Year) 9/1922	9. Birthplac Country MA	e (State or Foreign)
	iand iow		10a. State 10b. County		10c. City, Town	or Location					10d.	. Inside City Limits
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ylar		ToE	Edward H. Russell				M	ildred	l Oliver		,	
Maryland	an an an an an an an an an an an an an a		J. Kelly Russell						Rural Route Numb			ode)
	1 and 1 Health iem 27		20a. Method of Disposition	5011	20b. Place of D	Disposition (Nan	ne of	Caroi	nsville,	20c. Location		, State
JOIL	00		1 Burial 2 Cremation 3 '4 Donation 5 Other (Specification)		cemetery, Crownsv	crematory or or		_ _ 2/1	/2005		0.5444	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer		CLOWIEV	22. Name an		A Constitution		Crowns	100	sville, Inc.
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99	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	9	IF FEMALE:									
Вох	leath certifica attending phy for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic pro					ite of delivery onth Da	ıy Year
P.O. I	at the de by the a stached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	t time of death	5 Other (sp	ecify)					,
S, D	s that ned by	by Ph	Part II. Other significant conditions of	ontributing to death t	out not resulting in t	he underlying ca	ause given i	in Part I.	23e. Did t	tobacco use conf	tribute to the o	cause of death?
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<u>=</u>				anous	colitis				perfo 1 ☐ Yes		death? 1 🗌 Yes 2 🗆	□ No
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of	g Phys er this eral di	-	27. Manner of Death	28a. Date of Inju (Month, Da			8c. Injury at Work?		Home 5 Resi	how injury occur		· · · · · · · · · · · · · · · · · · ·
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	ijury - At home, farn tc. (Specify)	n, street, factory	, office		28f. Location (City or To	Street and Numb wn, State)	oer or Rural Re	oute Number,
	pital ours a leral C		29a. Certifier 1 Cartifying Ph	ysician: To the best	of my knowledge	death occurred	at the time	date and nia	ce and due to the	cause(s) and ma	anner as state	ıd
	e Hos 124 h ia Fun iletely	Medical	(Check only 2 Madical Examone)	niner: On the basis of and manner si	of examination and/	or investigation,	in my opini	ion, death oc	curred at the time,	date and place,	and due to the	e cause(s)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	M	29b. Signature and title of certifier	(4:0		290	License nu	Anna a	2	29d. Date signe		
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0	L '		30. Name and address of person who $5851 - \text{De } al$. 1		_		reale		ANA 200	7 (-1	
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State

111 Penn Street Baltimore, Maryland 21201

who completed cause of death (Item 23a) (Type, Print)

MO

Jouthall

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		X	Decedent's Name (First, Middle, Last)	0 1	1		2. Date of Death		3. Time of Death
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1	Examir	er	4a. Facility Name (If not institution, give street and number)	11000		Location of Death		4c. County of Dea	ith
	Funeral		5. Social Security Number 6. Sex 7. Ac	e (In yrs. last birthday) If Under 1 Year	OS Q If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
ь	Director		286-18-7910 ^{1⊠M 2□F}	83 Yrs.	Months Days	Hours Min.	(Month, Day, Yea	922 Ohi	ountry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
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	th the or 28a and i	Director	10e. Street and Number	OOTUM	10f. Zip Code		10g. (Citizen of What Co	ountry?
	23e c	raiD	10001 Windstream Drive #10)7	21044	i .		U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 Is marked other than "naturel", or Items 23e or 28a-f ehoweny injury or other treumatic event, I've Modical Ever in an Le notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
21215-0036	tural	ed b	3 Widowed 4 Divorced Year or Dates:	16a Dec	edent's Usual Occup	ation	16h	Kind of Business	White
215	nin 72 In "na Meals	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or:	(Giv	e kind of work done of DO NOT use retired	during most of workir f)	ng lab.	Kind of business	vindustry
	ed witt	Com	4	'	l Investig	gator		Private	
Maryland	be file	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	,	
ž	hould d Mer marke maric	2	William L. Richards 19a. Informant's Name/Relationship (Type, Print)	10h Mail	ing Address (Street a		Dickensh		T- C- (-)
	ad 2 s lith an 27 Is I		Frances Richards (Wife))l Windstr				
re,	item other		20a. Method of Disposition	20b. Place of Disc		I D		Location - City or	
altimore,	Page		1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	I .	n Nationa	1	2005 Ar	lington,	Virginia
Balt	permit. Departr Imports eny inji		21. Signature of Duneral Service Licenses	/ X T	2. Name and Addres	eral Home	s, Inc.	hia Mar	yland 21045
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li					oza, nar	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ntia					Onset and Death Un Known
	/Medical Examiner		resulting in death) Due to (or as	a consequence of):					
	1	eľ		a consequence of):					
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
Ö,	a exadian ari	Exa		a consequence of):					
8760	cate ba exacuted physician and the burial-transit	dical	d						
Box 6		√/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy				23d. Date of del	iven
4		Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
о. О	at the 1 by th stache	Phys	9 ☐ Unknown 9☐ Unknown						
Records,	Tha law requires that the te has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death b	ut not resulting in the t	underlying cause give	en in Part I.		/	the cause of death?
ecc	law requias been	Completed					24a. Was an autopsy	prior to d	stopsy findings available completion of cause of
		Con					performed? 1 ☐ Yes 2 ☑ N	death?	
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?		Othe	26. Place of Death			
ō	y Phys er this eral dii	\vdash	27. Manger of Death 28a. Date of Inju	ry 28b. Time o	of 28c. Injury	at 2	e 5 Residence		cify)
<u>0</u>	nding Fath. r.: After re funer	atio	1 Matural 5 ☐ Pending (Month, Da) 2 ☐ Accident investigation	y Year) Injury	M 1 🗆 Y	:? /es 2 □ No			
Division of	I or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurial building, etc.	ury - At home, farm, st c. (Specify)	reet, factory, office	2	8f. Location (Street a City or Town, Sta		ıral Route Number,
	spital cours af								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medicel Exeminer: On the basis of and manner sta	ot my knowledge, dea examination and/or in tted.	th occurred at the tim evestigation, in my op	e, date and place, a finion, death occurre	nd due to the cause(d at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the Within Comp	ž	29b. Signature and title of certifier		29c. License	number	29d. D	ate signed (Month	h. Day, Year)
			John S. Call	MD	343	SYLOH	2 (0)	2 22	2005
			29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of d 31. Date filed (Month, Day, Year) MAR 0 1 2005	eath (Item 23a) (Type	Print) Role	times MA	vul-12	12/8	
	Sta		31. Date filed (Month, Day, Year) 32. Resistra	ar's Signature		(June -	, 5	
	Registr	ar	MAR 0 1 2005	me & A	more				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	arylan	d / Depa		t of H	ealth a	and M			00	5	06713)
	Physicia		1. Decedent's Name (First, Middle, Las	it)							2. Date of Dea			ear	3. Time of Death	/
	Physici /Medio		William	Rosenaue	r						FEB	25	20	25	7:00P	٧f
	Examir	er	4a. Facility Name (If not institution, give 7 Ferdinand Ave.	street and number)			1		Location of			4c. County of Death Anne Arundel				
	-		5. Social Security Number 6. S	ex 7. Age	e (In vrs. I	ast birthday)		1 Year	Burni If Under		8 Date of Birt					
	Funeral Director			X M 2□F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Date 8-13-1	914	3	Count	ace (State or Foreig try) MD	<i>µ1</i>
	yland 10w		10a. State 10b. County		10c. City	, Town or Lo	cation							10	Od. Inside City Limits	s
	e-fal	ctor	MD Anne Ar	unde1		Glen	Burni	Le							1 ☐ Yes 2 🕅 No	0
	be tiled within 72 hours after death with the Maryland tal Hygiene. Id other than "neturel", or tlems 23a or 28e-f ahow event. The Modical Exertings must be retified at	Funeral Director	10e. Street and Number 7 Ferdinand Aven	ue			10f. Zip	Code LO61				10g. Cîtiz	en of Wha	ut Count USA	try?	
	ems ;	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.	S. 13.	Was Deced	dent of His	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	1	4. Race -	America White, e		
36	satte , or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 X Yes 2 ☐ N If Yes, Give	lo		1 🗆 Yes		Specify:		,,		Specify:		ite	
0	turel	edt	15. Decedent's Ed	Year or Dates: ucation		16a. Deced	dent's Usua	al Occupa	tion			16b. Kin	d of Busin			
215	hin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	4)	(Give life. l	kind of wo DO NOT u	rk done d se retired)	uring mos	t of work	ing				-	
21	tiled wit Hygiene other tha	Com	12			Cost	Acco	unta	nt			Man	ufact	curi	.ng 	
Maryland 21215-0036	should be tiled withir na Mental Hygiene. marked other than metic event, to M	To Be (17. Father's Name (First, Middle, Last) Michael Valent	ine Rosen	auer					er's Name Lean	e <i>(Fir</i> st, <i>Middl</i> e, ora Haa		Sumame)			
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other treumetic ev once.		19a. Informant's Name/Relationship (7 Mrs. Patricia Hill	• • • • • • • • • • • • • • • • • • • •							al Route Number		Town, Sta 21120		Code)	
ore,	es 1 a of Hei fitem rothe		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆	Damaual from State	20b. PI	ace of Dispo emetery, cren	sition (Nar.	ne of ther place	e)		Date		ation - Cit	-		
Ĕ	Pag ment ant: I		'4 □Donation 5 □ Other (Specify			Ly Cro	ss Ce	mete	ry				imore			
Baltimore,	permit. Depart Import eny inj		21 Signatur of Funeral Service Licen	3 M	136	$4 \begin{vmatrix} 1 \end{vmatrix}$	Secor	d Address	s of Facilit e SW	y Sin , Gle	gleton en Burn	Fune Le MI	ral H 210	lome 61	P.A.	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mod	e of dying	, such as	cardiac o	or respiratory an	rest,			Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	a. PR	OST	ATE	LAX	2011	iom	A					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as												
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequ	ence of):								_		
-	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events			,-										
oʻ	an an		resulting in death) Last	Due to (or as a	consequ	ence of):								-		
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	Ical		d												
9	teath certifica attending ph d for use as tl	Med	IF FEMALE:	00- 16	-							- 1				
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 🗌 Fetal	death 3	Ectopic pr					23	3d. Date of Month		y Day Year	
P.O.	at the de by the a stached	Physician/Med	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown	ante or de	all J_	1 Other (sp	ecily)								
	as this	by	Part II. Other significant conditions of	ontributing to death bu	it not resu	Iting in the ur	nderlying c	ause give	n in Part I.						cause of death?	
Sor	w require been si should I	etec														_
Il Records,		Completed									24a. Was a autop: perfor 1 Yes	sy med?	prior deat	r to com	sy findings available pletion of cause of 2□ No	9
Vital	ysicien: Th is certiticate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only or					
o	Phys	1: To	1 Yes 2 No	1 🗀 Inpatiei		ER/Outpatien 28b. Time of		8c. Injury	' 4 □ Nu at		me 5 Resid 28d. Describe h			Specity)		-
Division	Attending Physicien: r death. ector: After this certilics by the tuneral director, I	catior	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injur (Month, Day	Year)	Injury	М	8c. Injury Work 1 🗆 Y	? es 2 □ t			y				
DIX	tal or Ati s atter d al Direct ed in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At hou . <i>(Specify</i>	me, farm, stre	eet, factory	, office			28f. Location (S City or Tow		Number o	or Rural	Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the	edical (29a. Certifier 1 PCertifying Phyone) 2 Medical Exemption	ysicien: To the best of iner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred restigation,	at the time in my opi	e, date and inion, deat	d place, a	and due to the c ed at the time, d	ause(s) a ate and p	nd manne lace, and	er as sta due to t	ted. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier					. License					signed (M			
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	12	134	30. Name and address or from who of the way and address or from who of the way and the way	completed cause of de	ath (Item	23a) (Type,	Print)	دين	n	cill	ersul	u-e	, n	20	21108	
:-	Sta		31. Date filed (Month, Day, Year)	2. Registra	r's Signat	ure	W		,							
	Registr	वा	MAR U I ZUU	J Electron	1	19	-									

Marvin L. Shipley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-01322 State of Maryland / Department of Health and Mental Hygiene 23a,27,28a-f per Registrer Registrer DS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 19, 2005 **Physician** 2229 р м Marvin L. Shipley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, APR 7, 196 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1**∭**M 2□F 219-90-3826 Director 1964 Maryland Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f shov Item 27 is marked other then "natural", or Items 23e or 28a-f show other traumatic svent, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Walkersville Frederick Maryland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8790 Victory Court 21793 USA a filed within 72 hours after death and Hygiene.
Other then "natural, or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automotive Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F should be William Earl Shipley Janet Yenser 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 item 27 i 5175 Buffalo Road Mount Airy, MD 21771 Donna Curley/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ Department of Importent: If any injury or gone. * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/27/05 Baltimore, MD 21. Signature of Funeral Service Licensee
Fdward A. Gregorchik ²². Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fentanyl Intoxication and Cocaine Use disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Each of ordiffic Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the IF FEMALE: for use If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an page 2 s 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XYes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Found 28b. Time of 28d. Describe how injury occurred Certification: Found 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 🛣 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 10:15 6X Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Anne Arundel** 4 Homicide Hospital Medical Center Annapolis, Md within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 21, 2005 OCME unte mull w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1AVUS NTD

MAR 0 1 2005

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

111 Penn Street Baltimore, Maryland 21201

KUREL

32. Registrar's Signatur

			1- State of Maryland / Department of Hea 1- State Amend Item 2 per phy G841 3-8-05 tas Registrar Amend Item 18 per informant Certificate of De	alth and Men eath G841 3	ntal Hygiei -16-05	ne 005 N∉as	06715
	Physicia	an	1. Decedent's Name (First, Middle, Last) Frederick A. Sipes Sr.	2.1	Date of Death Month	Day 28 Year	/: /5 A M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) Mariner at North Arundel 4b. City, Town, or Loc Glen Burn	cation of Death	bruary	4c. County of Dea	ath
Ī	Funeral Director			Under 24 Hrs. 8. I Hours Min. NO	Date of Birth (Month Day, Ye	9. Bi	rthplace (State or Foreign Synthy) 'Y Land
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mar 9-f st	ţo	Maryland Baltimore Cockeysville				1 □ Yes 2√√ No
	3a or 28	il Director	10e. Street and Number 10f. Zip Code 232 St. David Court #201 21030		_	Citizen of What C	
036	be filed within 72 hours after death with the Maryland Ital Hygliene. od other than "naturel", or Items 23a or 28e-f show event, I'ra Mudical Examiliar could be incitified at	by Funerai	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces? 1 Army 13. Was Decedent of Hispatifi Yes, specify Cuban, M 15 Yes, Give 1 Yes, Give 1 Yes 2 No Signature anic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.	
2-0	72 ho natur	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done durin	in ing most of working	16b	. Kind of Busines	s/Industry
Maryland 21215-0036	within ene. than *	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) ICE Man		Ow	n Busine	ess
1d 2	illed Hygie other	Be Co	17. Father's Name (First, Middle, Last) 18.	3. Mother's Name (Fi	rst, Middle, Maid	den Sumame)	
/lan	2 should be and Mental Is marked o eumatic eve	To B	Clarence Sipes	Elsie W, W	Vink Mal	bel E. W	isner
lan,	2 sho		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and</i>				
	s 1 and 2 of Health a item 27 is other trei		Joanna S. McKain - Daughter 232 St. David Co	ourt #201 Marc h ate		SVILLE, Location - City o	MD 21030
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other treumatic er		1 Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify)	2005			e, Maryland
Bai	permit Depar Impor any in	. 13	21. Signatur of Funeral Service Licenses ### Reme and Red Service Licenses 421 Crain Hi				21061 Maryland
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, st shock, or heart failure. List only one cause on each line.	such as cardiac or re	spiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Coloniary ARTER 7 resulting in death)	1 DISE,	ASE		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	7	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	acuted ind transi	Examiner	that initiated events c.				
68760,	ficate be executed physician and is the burial-transit	edicai Ex	Due to (or as a consequence of):				
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of di Month	alivery Day Year
ds, P.O.	uires that I n signed by Id be deta	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Severe Deservative Tour Dis				to the cause of death?
Vital Records,	The law require ate has been si page 2 should b	ompleted			24a. Was an autopsy performed	prior to death?	autopsy findings available ocompletion of cause of
/ita	siclan: Th certificate rector, pag	BeC	examiner /	6. Place of Death (Ci			
of	Physi this c	.To		4 Nursing Home	5 Residence		ecify)
	th. : After funer	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?	s 2 No	. Describe now i	injury occurred	
Division	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific- tely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Stree City or Town, S	t and Number or F tate)	Rural Route Number,
	To the Hospital or a within 24 hours after To the Funeral Direct completely filled in b	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, of examination and/or investigation, in my opinic and manner stated.	date and place, and ion, death occurred a	due to the cause at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License nu 29c. License nu		29d.	Date signed (Mor	nth, Day, Year)
1	(1						}
L	1		Fer Even MD 8 kg Ritchie High	vey Par	a Lene	Hoy	and 21122
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C				

State of Maryland / Department of Health and Mental Hygiene.

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Filomena 3:35 P M С. Spino February 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care Nursing Ctr. - Rossville Rossville Baltimore 8. Date of Birth (Month, Day, Year)
March 2, 1926 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days 1 □ M 2 1 F Months Hours Min. 048-16-4905 78 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County id other then "naturel", or Items 23s or 28e-f ehow event, the Medical Exercit at must be notified at 1 ☐ Yes 2 No Director Baltimore Maruland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Items 23e or: 21236 U.S.A. 4306 Soth Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mercy Hospital Paymaster 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maria Manascalco Vincenzo or other traumatic ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 Soth Avenue, Baltimore, MD 21236 Mr. Frank Spino (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Nother (Specify) Entambment
21. Signature of buneral Seames Licenses permit. Page Department of Important: If any injury or Dulaney Valley Maus. 3/02/2005 Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the dise se, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mean /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to initiodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy φ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 12 Yes 2 No 3 Probably 4 Unknown been significant 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 🗌 Yes 2/0 Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the nerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after ö To the Hospitel tha Funerel 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 101 29c. License number 91 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. M. R. Rahnama, 9512 Harford Rd., Suite 4, Baltimore, MD 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrer	State of Marylan			t of He			Reg. N	UU	5 0	6717
Physi	cian	Decedent's Name (First, Middle, Last,						2. Date of Month		ay	Year	3. Time of Death
/Me		Rivers	Rafter	·		Stev		FEBR.				0221 M
Exam	iner	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or I	Location of Dear	th	4	lc. County	of Death	
		Union Memorial		6-46'46 (c. 1		timc r1Year	ore If Under 24 Hrs		1000			
Funera Directo		216-58-3564	7. Age (In yrs. 51	Yrs.	Months		Hours Min.		Day, Yea 04	^{r)} 53	9. Birthpl Count N	
and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation						10	Od. Inside City Limits
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the 1	le c	MD NA	Bal	timor	e 10f. Zip	Code			10g (Citizen of	What Count	nv?
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or Ite	F	1 Never Married XXMarried	Armed Forces? 1 ☐ Yes 2 📉 No		_		, Mexican, Puer	to Rican, etc.)		ck, White, e	etc.
5-UUSD 72 hours after death with the Maryland neturel', or Items 23a or 28a-f show dical Examblist must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	'	☐Yes	2 X No	Specify:			Specif	у: В 1 а	ack
ING ZIZIS-UUSO be filed within 72 hours after death with the Marylan ital Hygiene. nd other then "neturel", or Items 23a or 28a-1 show event, the Medical Example of matter the notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	kind of wo	rk done du	tion uring most of wo	orkina	16b.	Kind of B	usiness/Ind	ustry
21215-0036 d within 72 hours afl gjene. er than "natural", or ina Medical Exam	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT u	se retired)						
e filed within I Hygiene.	S	12th grade 17. Father's Name (First, Middle, Last)	na	Seaf	ood					Supe		cket
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Maryland of 2 should be file lith and Mental Hy 27 Is marked oth	2	Alvin Stewart 19a. Informant's Name/Relationship (Tr	na Drinti	105 14-15-	- 4-1-1		lable F				O: . =:	
Ma nd 2 sl lilth an 27 Is r r traur							nd Number or R					
the area		Patrice Stewart 20a. Method of Disposition		Place of Dispos			reeper	St.,			Md City or Tov	2 <u>1205</u>
Baltimore , bermit. Pages 1 a Department of Hes important: If item any injury or othe		1√2 Burial 2 ☐ Cremation 3 ☐ F	removar from State Ma	emetery, crem rylan	atory or o	ther place	al		200.	Looding	Ony or rot	in, dialo
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		23a. Part1. Enter the disease, or compl	ications that caused the deat				sh Ave			re,		21215 Approximate
100 0		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.						y arrost,			Interval Between Onset and Death
Pnysicia /Medica		disease or condition resulting in death)	METABOL	IC	A	CII	POSI	5.				3 days
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	e e	Sequentially list conditions,	Due to (or as a conseq		17							augu
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ob fou, ficate be executed physician and s the burial-transit	edicai		J									
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death certif	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live birth 2 ☐ Feta		Ectopic pr	regnancy					te of deliver	
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_ F # 6			·						erformed?		death?	No
OT VITAL I Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:			Other	26. Place of De					
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⊏ E e € €	tion	1 Matural 5 ☐ Pending	(Month, Day Year)	Injury	M	28c. Injury a Work?	es 2 🗆 No	200. 00301	DO HOW IN	ury occur	80	
or Attending or Attending ifter death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, stre			4011	28f. Locatio	n (Street a	and Numb	er or Rural	Route Number.
DIVISION I or Attending after death. Director: Afte	Certification:	4 Homicide	building, etc. (Specif	y)		,,		City or	Town, Sta	te)		
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C	(Check only 2 Medical Exami	sicien: To the best of my kno ner: On the basis of examina	wledge, death	occurred estigation.	at the time	, date and place	e, and due to urred at the tir	the cause(s) and ma	inner as sta and due to t	ted. the cause(s)
hin 2, the I	Med	29b. Signature and title of certifier	and manner stated.			c. License						
To To		2.50. Signature and this of certified	inell a	10							d (Month, D	
16		MIMINIT	mu "	111		HT 8	24389	146	2	-2	6 -0	2005
N	A COLUMN TO SERVICE AND SERVIC	30. Name and address of person who co					l an reservi	- 4 -			2121	8-2.895
	tate	31. Date filed (Month, Day, Year)	32. Regerar's Signa	iture			21 UNIV	ERSIT	Y PAS	LANA.	Y BALT	IMERE, ME
Regis			005	K A	model		,	1				

		•	For State Registrar	State of Ma			ment of H		and Me		iene	005	06718
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea	th		3. Time of Death
	Physicia /Medic		Arementa C. Sharp	е						Month Februar	v 26.	Year 2005	11:00 A.M
	Examin		4a. Facility Name (If not institution, give			4b	. City, Town, or	Location of				nty of Death	
ı			5703 Anthony Ave.					imore				N/	
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last bin 82		Under 1 Year onths Days	If Under	Min.	8. Date of Birth (Month, Day Sept • 17	Year	9. Birth	nplace (State or Foreign intry)
	Director		209–12–8143			113.			,	sebr.11	,1922	Car	lisle,PA.
	/land		10a. State 10b. County		10c. City, Town	n or Location	on						10d. Inside City Limits
	Mar-fal	ţ	Maryland N/	A	Baltin	nore							1 XYes 2 No
	th the	Directo	10e. Street and Number				0f. Zip Code			1	0g. Citizen	of What Cou	untry?
	23a		5703 Anthony Ave.				212				Ţ	J.S.A.	
	terms	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of Hi s, specify Cuba	ispanic Ori n, Mexican	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	14. F	Race - Amer Black, White	ican Indian, , etc.
9	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ 1 If Yes, Give Year or Dates:	No.	10	Yes 2XNo	Specify:			Spe	city: Wh	nite
5-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Medical Examinat must be notified at		15. Decedent's Edu	ucation	16a.	Decedent'	's Usual Occupa	ation			16b. Kind of	f Business/I	ndustry
212	d within 72 ho giene. ir than *natui tre Medical	piet	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5		(Give kind	d of work done o NOT use retired	durina mos	t of workin	g			
7	d with	Completed	12	2			Secr	etary	•		SDA	Churc	ch School
2	be filed ttal Hygin of other event, tt	Be (17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sum	name)	
<u>X</u> a		2	Samuel Cornelius							ae Nick			
Maryland	2 2 2 2		19a. Informant's Name/Relationship (T		ghter) ^{19b}	. Mailing A	ddress (Street a						ip Code)
	1 and 1 Health tem 27		Shelly (nee Sharp 20a. Method of Disposition	e) Gair	5 20b. Place of		ok Cour	t Ba	ltim	ore, Ma	ryland 20c. Locatio		236-5022
altimore,	6 O		1X Burial 2 ☐ Cremation 3 ☐		cemeter	ry, cremato	ny or other plac	!	Marc	ch			
	permit. Pag Department Important: I any injury o	1	4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licent		Parkwo	ood Ce	emetery		02,	2005	Baltir	more,	Maryland
Ba	Dep fmp any	. 4	1 Jether F. 4	7/10		I Cal	ceful A	1tern	ative	es Fune	ral ar	nd Cre	mation Ctr.
			23a. Part1. Enjer the disease, or comp shock, or heart failure. List of by	lications that caused	M00677) I the death. Do i	not enter th	5 York	KO • 'I g, such as	cardiac or	respiratory arr	y Land est,	2109	Approximate
	Physician		Immediate Cause (Final	0			•						Interval Between Onset and Death
2.5	/Medical		disease or condition resulting in death)	a. Che 5n	a consequence		icci aer	~(1 week
	Examiner		Sequentially list conditions	b									
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	oi).							
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8760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E				,-							
687	ficate p physics the	edic		0									201
ŏ	leath certific attending pl	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		ه ⊐⊏-۰					23d.	Date of deli-	very
<u> </u>	deatl	Physician/Me	in the past 12 months? 1 □ Yes 2 X No	4 ☐ Pregnant at	2 ☐ Fetal death time of death		opic pregnancy her (specify)				T	Month	Day Year
P.0	that the de led by the a detached	Phys	9 Unknown										
	ires tha signed be det	by	Part II. Other significant conditions co	entributing to death b	ut not resulting in	n the under	rlying cause give	en in Part I.	•		V		the cause of death?
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3ec	e law has b	mpi								24a. Was a autops perfor	sy	b. Were aut prior to c death?	opsy findings available ompletion of cause of
a	olcien: Th certificate rector, pag									1 ☐ Yes	2□No	1 🗆 Yes	2□ No
Ĭ	elcie certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0/7/EB/O	tantinat (Othe	26. Place er: 4 □ Nu		(Check only or		041 (0	
ō	Phys r this sral di	<u> -</u>	27. Manner of Death	1 ☐ Inpatie	ry 28b.	Time of	3 DOA 28c. injury Work			8d. Describe h	ence 6 ⊡0 ow injury oca		ity)
lon	Attending Phyelcien: r death. ector: After this certifica by the funeral director, I	atio	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	njury		k? Yes 2□	No				
Division of Vital Records,	or Attendi after death. Director: A in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	289. Place of inj	ury - At home, fa c. (Specify)	ırm, street,	factory, office		2	8f. Location (S City or Town		ımber or Ru	ral Route Number,
ā	tel or A	Cer		1									1
	To the Hospitel or Attending Phyelcien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical Exam	ysician: To the best iner: On the basis o	f examination an	e, death oc	curred at the tim	ne, date an pinion, dea	d place, a	nd due to the c	ause(s) and late and plac	manner as ce, and due	stated. to the cause(s)
	the I	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License						, Day, Year)
)	5 × 10 × 10		200		_		D.	170	u I	2		4R	
	in		30. Name and address of person when	Ompleted cause of a	leath (Item 23a)	(Type Prin		. 10	7)		, , , , , ,		- 3
	13		MARI I. LEAU	_	1205	YORK	ROAD +	32	LUTH	ERVILLE	MO	210	93
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signature	and)							
h	Regist	rar	MAR 0 1 2005	KIR SOLLAR	Dr. Viel								

			1- State of Maryland /	Department of Health and Me Certificate of Death	ental Hygien	-000 00112
		36 .	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
И	Physicia /Medic		Anna MARIZ STRACK	- 4	FEBRUAR	24 2005 3:50 P.M.
	Examin	100	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
7		, di	aso Riobe Ave.	Towson	(SALTIMORE
г	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
Н	Director		Usual Residence of Decedent		01 EB-TAZ 10	US WARRENO
	yland yland		10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
	e-f s	ctor	newson Callinga Tav	NJ24		1 ☐ Yes 27 No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath w		250 RIOW AVE	2/28/2		V.S.A.
	er de Items	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 % No If Yes, Give 9	1 ☐ Yes 2 No Specify:		Specify:
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or Items 23s or 28e-f show event, the Medical Evarient must be notified at	ted	15. Decedent's Education 16	6a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
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	filed with Hygiene. ther ther	Con	19762	HOMEMAKER		AT Home
and	be fil Ital H od oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	
충	should I	To	19a. Informant's Name/Relationship (Type, Print)	KATHER	*1.1.30-	unb
Maryland	d 2 she th and 7 is m treum		0 = == 1:	9b. Mailing Address (Street and Number or Rural	177	or Town, State, Zip Code)
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JOH.	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	tery, crematory or other place)		V. M. O.M.
altimore,	그 돈 뿐 글		21. Skin Mr. Funer: I Bervice Lice see	22. Name and Address of Facility		WATE HANDON
ä	Depared Impo		Too Wood	2 120 HAD2TOK OBS	NORUS	000/190 (2) 21/2
r	- A		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition Malisment	Melarom		Opsel and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence			1
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Т	ted nsit	nine	Cause (Disease or injury	e 01).		
Ć,	execunand nand ial-tra	Examiner	that initiated events c	ea of):		
8760,	icate be executed physician and s the burial-transit	dical	d			
9	rtifica ng ph as th	Medi	IF FEMALE:			
Вох	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ath 3 Ectopic pregnancy	-	23d. Date of delivery Month Day Year
o.	the a	/slc	1 ☐ Yes ﷺ No 4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day real
<u>α</u>	that the	Ph	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	se de de	d by		, , , , , , , , , , , , , , , , , , , ,	1 ☐ Yes	No 3 Probably 4 Unknown
00	w require been si should	Completed			24a. Was an	24b. Were autopsy findings available
	The lav	omp			autopsy performed?	prior to completion of cause of death?
Vital		0	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 N	0 10 105 20 100
of <	di S	To B	examiner? 1 ☐ Yes ※▼ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence	6 ☐Other (Specify)
Ē			27. Manner of Death 28a. Date of Injury 28b 1 X Natural 5 ☐ Pending (Month, Day Year)	b. Time of 28c. Injury at 28 Work?	8d. Describe how inju	ury occurred
Sio	death.	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	l or Atten after deat Director:	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	City or Town, Sta	and Number or Rural Route Number, te)
	spitel		29a. Certifying Physician: To the best of my knowled	ge, death occurred at the time, date and place, ar	nd due to the cause(s	s) and manner as stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred	d at the time, date ar	nd place, and due to the cause(s)
	To the Hospitel within 24 hours a To the Funerel completely filled	Me	29b. Signature and title of certifier	29c. License number	29d. D.	ate signed (Month, Day, Year)
	1		Clh Calaluful 100	024356	FEC	RUANY AS ATTOS
	5		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print) Weenbery Concyl	enter at	Fronte Squan
			Um C Water field MW 9/03 P	ronkles squar to. Do	utime the	121234
	Sta Registr	7	MAR 0 1 2005 Januar &	Joseph Squa D. Br		
			A DECOME THE LOUD MAN STORY			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			_ 101	f Maryland / D	epartment of H	lealth and Me	ental Hygid	ene	
			1 - State Registrar		Certificate of I	Death	Reg	I.No. 0 0 5	06720
	Dhuaisi		1. Decedent's Name (First, Middle, Last)	C	I.L.		2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Michael	Sacile	OTTO		epruaru	23 200	5 6:45pm
	Examin		4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or	Location of Death	3	4c. County of Dea	th
		-35		idical Lent-	er Baltin	nore			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,) May 29,	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		212-01-9135 Usual Residence of Decedent	89 Y	rs.		May29,	1915 MAr	yland
	land		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Many	ō	MD Baltimore		Essex				1 Yes 2 No
	the	Director	10e. Street and Number		10f. Zip Code		100	. Citizen of What Co	ountry?
	3a o	0	311 Oberle Ave.		212	21		USA	•
	filed within 72 hours after death with the Maryland Hygiene. that than "natural", or llams 23a or 28a-f ahow ant, the Modical Examinant man be notified a	Completed by Funeral		edent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spec	ify Yes or No-	14. Race - Ame	
9	after or ita	Fu	Armed For 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Gi	2t☑No		in, Mexican, Puerto R	ican, etc.)	Black, Whi	·
ဗ္ဗ	ours iral',	db	3 Widowed 4 Divorced Year or D	ates:	1 ☐ Yes 2 ☐MNo	Specify:		^{Speci} ₩hi	te
21215-0036	72 h	ete	 Decedent's Education (Specify only highest grade completed) 	16a. I	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	ation during most of working	16	b. Kind of Business	/Industry
2	vithin ne. han	m	Elementary/Secondary (0-12) College (1-4or 5+) Se	1 f = DO NOT use retired $1 f$ = employed	ed		Bricklay	er
	Hygie thart	ပိ	3rd 17. Father's Name (First, Middle, Last)			18. Mother's Name	(First Middle Ma	uidon Sumamal	
and	ntal hed of	Be	Valentine Sacilott	0		Amelia			
Maryland	should d Me mark matic	10	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street a				Zin Code)
<u>≅</u>	ith ar 27 is trau		Marie SAcilotto / w	. 1	11 Oberle				
ē,	s 1 ar f Hea itam 3		20a. Method of Disposition		Disposition (Name of y, crematory or other place			c. Location - City or	
9	Pages ent of ht: If i		¹☎ Burial 2 ☐ Cremation 3 ☐ Removal from ¹ 4 ☐ Donation 5 ☐ Other (Specify)	State	v. crematory or other place n Cemetery		/05	Baltimor	o MD
Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or tlams 23a or 28a-1 ahow any njurry or other traumatic avent. It is Marileal Examinator and be neithed at 2006.		21. Signature of Funeral Service Licental	5201	22. Name and Addres				omeofEssex
Ö	Depo Impo any ir		K. Turn Con as	· llas	300 M	ace Ave.	Balti		21221
4		1	23a. art1. Enter the disease, or roculications that of shock, or heart failur.	aused the diata. Point	ot enter the mode of dyin				Approximate
	Physician		Immediate Cause (Final	c - 1 1	Lowered				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to	(or as a consequence o	Nemorr	nage			Hours
6	Examiner		Sequestially list and divines	ebral Vas	scular Ac	cident			day
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence o	f):				1
,	ecute ind trans	Examiner	that initiated events c.						
, 0,	oe execian a	Ě	Due to	(or as a consequence of	of):				
38760,	icate be executed physician and the burial-transit	edical	d						
			IF FEMALE:	tcome of pregnancy					
Вох	eath certif attending for use a	ian	in the past 12 months?	birth 2 Fetal death	3 Ectopic pregnancy			23d. Date of de Month	livery Day Year
P.O.	the de	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Flegi 9 ☐ Unknown 9 ☐ Unkn		5 Other (specify)				
	es that the death cer igned by the attendin be detached for use		Part II. Other significant conditions contributing to d	eath but not resulting in	the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	The law requires that the death certif ite has been signed by the attending cage 2 should be detached for use a	d by	Hypertension atrial-	fibrillati	M		1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
CO	w require been si should I	lete	11				24a. Was an	24b. Were a	utopsy findings available
Re	he tav e has age 2	Completed		-			autopsy performe	prior to death?	completion of cause of
tal		a	25. Was case referred to medical			26. Place of Death	·	No 1 Yes	289,No
<u>></u>	Physician: this certific ral director,	o B	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Out	patient 3 DOA Othe	or		ce 6 Other (Spe	cify)
J Of	ig Ph ter th	n: T	27. Manner of Death 28a. Date	of Injury 28b. Ti		y at 28	d. Describe how		
ior	Attanding or death. actor: After by the funer	atic	2 ☐ Accident investigation	u, 24) (da)		Yes 2 □ No			
Division	r Att	Certification:		of Injury - At home, faring, etc. (Specify)	rm, street, factory, office	28	If. Location (Stre City or Town,	et and Number or R. State)	ural Route Number,
	itel or rat D rat D								
	To the Hospitel or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only only) 2 Medical Examiner: On the bounds of t	asis of examination and	, death occurred at the ting For investigation, in my or	ne, date and place, ar pinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)
	thin 2 thin 2 tha mple	Med	one) and man 29b. Signature and title of certifier	iner stated.	29c. License			I. Date signed (Mont	
	F 3 F 8		Do Helly & You	tman Br	40	5-000			
•	7		30 Name and address of person as completed and		.,,	, 000	115	July y	
	10		30. Name and address of person the completed cau	UC , 494(3 Fostern	Avenue,	Baltin	ore, MN	3,2005
	Sta	te	31. Date filed (Mouth, Day, Year) 32. F	strar's Signature	2	1100100		1 11	4.00
100	Registr		MAR 0 1 2005	Elecu &	Monet ,				

			T- State of Man		artment of Health and trificate of Death		giene Reg.No.005	06721
			Decedent's Name (First, Middle, Last)		- Dodin	2. Date of De		3. Time of Death
	Physicia		Norbert	George St	rub, Jr.	Month Februa	ry 21, 2005	10:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De		4c. County of Deat	
	Examin	Ü.	Howard County General Hospi	tal	Columbia		Howard	
	Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours M		th 9. Birt	hplace (State or Foreign
	Director		577-40-8421 ^{1໘M 2□F} 73	Yrs.	Months Days Hours N	in. (Month, Da Apr 15		untry) Libama
	D >		Usual Residence of Decedent 10a, State 10b, County 1	I0c. City, Town or Lo	antion			101 1-11 01 11 11
	sho	5			CallOff			10d. Inside City Limits 1 ☐ Yes 2 X No
	the N	Director	MD Howard 10e. Street and Number	Columbia	10f. Zip Code		40- 600	
	with		6336 Cedar Lane #134		21044		10g. Citizen of What Co	untry?
	eath	Funeral	11. Marital Status 12. Was Decedent Evo	erin U.S. 13.1	Was Decedent of Hispanic Origin?	(Specify Yes or No	U.S.A.	rican Indian
	fler of refer 표	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No	1	f Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	Black, White		
ဇ္ဇ	ours a	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Specify:		Specify: Whi	.te
0	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Te Madical Exacting mant be malified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of	working	16b. Kind of Business/	Industry
2	ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life I	DO NOT use retired)	Working	United Sta	tes
2	filed w Hygier other th		2	Exec	utive File Cler		Government	
ᇤ	be fill Hall Hall Hall Hall dot	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle,		
3	should be fand Mental Be marked of umatic eva	၉	Norbert George Strub			Mary Caza		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Branchent: If team 27 is arrived other than "natural; or Reartment results at any injury or other traumatic event, it a Madical Examinating that the nutilities at once.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or			
نه	1 an Heall am 2		Jan Hatzakos /daughter 20a. Method of Disposition	20b. Place of Dispo	Waterfall Drive	Date Date	20c. Location - City or	
ē	Pages nent of h ant: If Its ary or of		1 ☐ Burial 2 ☐ Cremation 3 🗵 Removal from State	-	natory or other place)			
altimore,	permit. Page Department of Important: If any Injury or once.		' 4 □ Donation 5 □ Other (Specify) 21. Signature if Funeral 3 are e Licensee		「emorial Park Fe 2. Name and Address of Facility	b 25, 05	Fairfax, V	rginia
ä	Dep Imp any onc			De	onaldson Funera 13 Talbott Ave.	l Home, P	.A.	707_4200
			23a. Part1. Enter the disease, or complications that caused th	ne death. Do not ent				Approximate
1	Pnysician	, ,	shock, or heart tailure. List only one cause on each line. Immediate Cause (Final		m. / 1			Interval Between Onset and Death
	/Medical		resulting in death)	ve Heart : consequence of):	Failure			
	Examiner		Advanced		ive Airway Disea	ase		
	H ESSE	ner		toneaquence of):				
	ocuted nd transi	Examiner	that initiated events					
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8760,	death certificate be executed e attending physician and od for use as the burral-transit	dicai	d <u>Diabetes</u>					
9 ×	eath certific attending pl	/Me	IF FEMALE: 23c. If yes, outcome of	pregnancy				
Вох	atten for us	ian	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
o.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	no or death 5	Other (specify)			
۵.,	that the led by th detache		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
rds	quires n sign	d by	Lung cancer			10'	Yes 2⊡No 3⊠Pr	obably 4 Unknown
Vital Records,	The law requires ite has been sign bage 2 should be	Completed	Severe peripheral vascular	disease		24a. Was	an 24b. Were au	topsy findings available
Be	The lav	mo					rmed? death?	completion of cause of
ta		0	Sepsis 25. Was case referred to medical		26. Place of	1 ☐ Yes Death (Check only of		2 110
	S S D	To B	examiner? 1 ☐ Yes 2X No Hospital: 1XXnpatient	2 ER/Outpatien	Othor		dence 6 □Other (Spec	cify)
n of			27. Manner of Death 1 XNatural 5 Pending (Month, Day Y	Year) 28b. Time of Injury			how injury occurred	
<u>Si</u>	Attanding r death. ector: After oy the fune	atic	2 Accident investigation		M 1 Yes 2 No			
Division	or Attan after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office	28f. Location (: City or Tox	Street and Number or Ru wn, State)	ral Route Number,
	Hospital or 24 hours afte Funaral Dir tely filled in		A			N.		h
	To tha Hospital or At within 24 hours after c Lg the Funaral Direc completely filled ≀n by	edical	29a. Certifier 1 X Xertifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of e: and manner state	xamination and/or in	h occurred at the time, date and pl vestigation, in my opinion, death o	ace, and due to the ccurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 Lo the complet	Med	29b. Signature and title of certifier	id.	29c. License number		29d. Date signed (Monti	n, Day, Year)
)	S. M. S.	1	1 Ga- M	5	D50870		February 22	
9 6	NV	Y	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type				
1	0/			al Bell L	,	le, Maryla	and 21029	
	Sta		31. Date filed (Month, Day, Year) 32. Segistrar	's Signature				
	Regist	rar	MAR 0 1 2005 Been	S. S. Se	noute .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CELESTERIA SHANNON 27, 2005 February 12:50am M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 212 20 3866 7. Age (In yrs. last birthday) 90 yrs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplece (St. (Month, Day, Year))
JUNE 22, 1914 VIRGINIA 6. Sex 9. Birthplece (State or Foreign **Funeral** 1 ☐ M 2 🖫 F JUNE Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "neturel", or iteme 23e or 28a-f show treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Director MD 1 XYes 2 No N/A BALTIMORE Shannon, (e) estno 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 U.S.A 7001 N. CHARLES STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: BLACK δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. 6Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental JAMES E. NORWOOD ELVIN THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA GREEN (niece) 6312 WIRT AVE. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. MARCH 4, 2005 BALTO, MARYLAND 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 21/Zignature of Funeral Service Licensee 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 days Physician Dreumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnap 3 Ectopic pregnancy in the past 12 mon Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be Completed by 2™No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NO or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Hospitel filled 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who con 200 32. Registrary Signature 31. Date filed (Month, Dec Year) State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2. Date of Death 2. Date of Death Month 2. Date of Death 2.			-	State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	Mental Hyg	iene 0 0 5	06723
Scale Service Servic		Dh		1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h	
Foundard County General Hospitals Columbia Columbia Assault (in the columbia Columbia			al		Feb	24 Zoo:	
Social Security Number Close Clo		Examin	er				
10.0 Columbia 10.0 Columbi		Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who congleted cause of death (Item 23a) (Type, Print)		urs af					
29b. Signature and title of certifier M.D. 29c. License number 29d. Date signed (Month, Day, Year) Feb Z 4, 2005 30. Name and address of person who competed cause of death (Item 23a) (Type, Print)		he Hosp in 24 ho he Fune pletely f	edica	one) Medical Examiner On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, da	ate and place, and du	e to the cause(s)
30. Name and address of person who corrupted cause of death (Item 23a) (Type, Print)			Σ	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mon.	th, Day, Year)
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Harry Li, 10780 Hickory Ridge Rd, columbia, MD 21044	_	1/)		Harry Li, 10780 Hickory Ridge Rd, Colum	mba,	MD2	1044
State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature	Ī	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 1 2005 32. Refistrar's Signature			
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amend item#20b, perFH, G841, 3/3/05 11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2005 11:30 SSE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner VIC Year Grace de tord HOSPITA a tartora If Under 24 Hrs. ial Security Number 8. Date of Birth (Month, Day, **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1₽M 2□F 344-26-409 Usual Residence of Decedent Months Days Hours Min Yrs. Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examiner must be notified at 1 PYes 2 □ No Completed by Funeral Director avre de fartorn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 220 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify: 3 Widowed 4 Divorced 19C "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ont: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 homas MMa 19a. Informant's Name/Relationship (Type, Print) 4rcm 1 19b. Mailing Address (Street and Number of Rural Foute Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of competer), cramatory or other place)

WODD (AW) (em, Department of Health a Importent: If item 27 Is any injury or other tree once. Havre to brace Small 20a. Method of Disposition 20c. Location - City or Town, State 3/3/2005 1, Burial 2 Cremation 3 Removal from State salto, md, * 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home 21216 Baltimore, Md W. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence Examiner Securitally let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ardiovoscular disease use as the burial-transit The law requires that the death certificate be executed signed by the attending physician and resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day page 2 should be detached for Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobapeo use contribute to the cause of death? Records. Be Completed by 1 Xes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?/ Yes 2 No 1 Tyes Vital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2000 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA of 28a. Date of Injury (Month, Day Year) Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Injury Chatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation M after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Hospitel within 24 hours a To the Funerel 6 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number person who completed cause 30. Nag e and address of 31. Date filed Month, Day, Year State 9 Registrar

			1 - State of Maryland / Department	artment of Health and M rtificate of Death	ental Hygier	7000	06725
	Dhysisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		CATHERINE S. THOMSON		FEBRUARY		5 6:15 ^{A M}
	Examin	er	4a, Facility, Name (If not institution, give street and number) HOLY CROSS HOSPITAL	4b. City, Town, or Location of Death STLVER SPRING		4c. County of Dea ONTGOMER	
	Funeral Director		5. Social Security Number 123-22-4256 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth JUNE 23,	9. Bir 1923 SC	thplace (State or Foreign DUTLAND
	Maryland -f show	tor	193 State 100. City, Town or Lo	ocation DD			10d. Inside City Limits
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	23a c		4458 OWENSVILLE SUDLEY RD.	20776		II.S.A	
9800	n 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show adical Examinar must be notified at	d by Funeral	1 Never Married 2 Married 1 Tyes 2 W No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: W	
21215-0036	C 2 50	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) SIDENT MANAGER	ng	Kind of Business	
Maryland 2	12 should be filed within n and Mental Hygiene. r Is marked other than raumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) DAVID SMITH	18. Mother's Name KATE GI	(First, Middle, Maid		COM LEX
lary	d 2 should the and Men 7 is market traumatic		TAILS II meren access and	ng Address (Street and Number or Rura			
	0 = 2		JOHN H. THOMSON/SON 44	158 OWENSVILLE SUD	LEY RD. HA	RWOOD, 1	ND 20776
Baltimore,	: Pages tment of tent: If it			BH. CREMATORY2/23/	05 LAU	Location - City or IREL, MD	
Bal	permit. Pag Department Importent: any Injury o		Jenja Stoward 18	2. Name and Address of Facility FLE 501 SANDY SPRING RI	D. LAUREL,	MD 2070	17
	Physician	i li	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	٠.	ē	Sequentially list conditions, if any, leading to immediate	VE LUNG DISEASE			
	od ansit	Examln	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
30,	ficate be executed physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760,	ficate b physic s the b	edical	d				
O. Box	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/Me		Dectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the u CHRONIC ATRIAL FIBRILLATION	nderlying cause given in Part I.			o the cause of death?
of Vital Records,		Completed by			24a. Was an autopsy performed:	prior to	utopsy findings available completion of cause of
/ita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death			
of	Phys this ral dii	. To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time o		ne 5 Residence 28d. Describe how in		city)
	Attending F r death. sctor: After by the funer	atlon	27. Manner of Death 1 ↑ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	ed. Describe flow in	july occurred	
Division	ipital or Attendi ours after death. nerel Director: A filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or R	ural Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl 2 Madical Examinar: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause ed at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To ti with: To ti comp	W	29b. Signature and title of certifier	29c. License number D 0 0 5 0 2	_	Date signed (Mont	1
	18		30 Name and oddress of person who completed cause of death (Item 23a) (Type, BRIAN SHEN, M.D. 1500 FOREST GLEN 1	Print) RD. SILVER SPRING.		101	12005
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2005	Sporte			

State of Maryland / Department of Health and Mental Hygiene 005 1- State Recistrar AMEND ITEM #26 PER PHY G841 C3 HINGON OF DEATH 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:00 AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 1804 Clermount Ct. Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🖾 F Yrs. 041-22-1114 Director 77 Sept. 11, 1927 CT Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic evant, the Madical Experiment. 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1804 Clermount Ct. Completed by Funeral 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 W. George Glenney Marian Swift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G.W. Tyrie, Jr./Husband 1804 Clermount Ct. Lutherville, MD 21093 20b. Place of Disposition (Name of Feb. 26, 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Comfort 1 4 ☐ Donation 5 ☐ Other (Specify) 2005 Crematory Alexandria, VA 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Road Timonium, MD 21093 21. Signature of Funeral Service hael J. Flagle 23a. Part: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** CARDIOMYOPATH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2. No 1 TYAS Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cother (Specify) this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No hours after death. investigation 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 2866 Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Khan, M.D. 7505 Ogler Drive Suite 103 Towson, MD 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1. Linder MAR 0 1 2000 Registrar

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem#2, perDVR, C840, 3/1/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont Feb. **Physician** Year Vernon K. Tracey 7414 2005 1600 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ST. AGNES HEALTHCARE N/ABATTIMORE
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Pay, Year) NOV 28, 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 ☐ F Mary Land 220-07-9221 86 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10h County 10d. Inside City Limits 28e-f shoy other traumatic event, it a Medical Examiner must be notified at 1 Yes 2 No Maryland Directo Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Heatth and Mental Hygiene. Inportant: if team 27 is marked other than "neturel; or tems 23a or 2 any injury or other traumatic event, it is Medical Examinar must be none. 5519 Heatherwood Road Be Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Water Plant Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Tracey Grace Sprinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean M. Tracey/wife 5519 Heatherwood Road Halethorpe, MD 21227 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 2/18/05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licenses Dawn McDonald 299 Frederick Road Baltimore, MD 21228
or the mode of dying, such as cardiac or respiratory arrest,
Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician MYOCArdiA Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GASTYOINSHINA see K Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of). by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2X No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 24 hours after deat Funeral Lirector: Divisi 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) Kydn Howald us Emergency Physi'i'an D0061564 cator Ave, Baltimore MD on Draw 900 State Registrar

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			Registrar		Cei	tificate of	Death		eg. No: UU	0 00/20
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Ba	Depa Impo any ir		21. Signature of Funeral Service License)				once Fune		ice, P.A. ryland 21225
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1/) 6		30. Name and address of person who cor	mpleted cause of death (Item :	23a) (Type,	Print)	-0007	.0 /	LIS/IUAK)	1 25,200
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) Co	Urol 1	talla	nn	d		OCME				Feb	oruary 26	5, 2005
			30. Name and address	ss of person who	completed cause of c	death (Item 2:	За) (Туре,		Dom	C+		D - 7 · ·			
	Sta	te	31. Date filed (Month)	Day, Year)	32. Registr	ar's Signatur	1		Penn	otre	et .	maltim	ore,	Marylan	d 21201
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For State Registrar		State o	f Maryla		irtment <i>tificate</i>			and M	lental Hyg	iene	05	06	730
1. Decedent's Name	e (First, Middle,	, Last)							2. Date of Deat			3. Tim	ne of Death
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		give street and nu	mber)		4b. City, T	own, or	Location	of Death	I EDITORI		nty of Death		25 A. M
STELLA		-	,			MON					TIMOR		
5. Social Security N		6. Sex	7. Age (In yrs	. last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth (Month, Day)				ate or Foreigi
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Jsual Residence of	Decedent									.,,,,	1211	T 02114F	
0a. State	10b. County		10c. C	ity, Town or Lo	cation							10d. Insid	le City Limits
MD	BALTI	MORE		TOWSON								1 📋	Yes 2 No
De. Street and Nu	mber				10f. Zip (Code			1	0g. Citizen o	f What Co	untry?	
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3 Widowed	44 Divorced	- Year or D			165 2	E3 NO	эрвину.			Sper	omy: WH	ITE	
(Spec	15. Decedent'	s Education t grade completed)		16a. Deced	kind of work	done d	uring mos	t of worki	ing	16b. Kind of	Business/I	ndustry	
Elementary/Seco	ondary (0-12)	College (1-4or 5+)	life. L	OO NOT use	retired,							
12TH GR				SECRE	TARY	OF F			PROBATIO			MARYI	AND
. Father's Name									e (First, Middle, I		ame)		
ANDREW	KOSINSK	I					FRA	NCES	WAWRZYN	JIAK			
9a. Informant's Na	ame/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street a	nd Numbe	or Aura	al Route Number	City or Tou	m, State, Z	ip Code)	
JANICE M	INK D	AUGHTER	,		DDEN '		EY D	R. 1	NEWARK.	DE 1	2711		
Da. Method of Dis 1 Burial 2 4 Donation	_isremation	3 □Removal from	State	Place of Disposementery, crem TRO CRE	natory or oth	er place	1			20c. Locatio Catoni			
1. Signatur of Fu	neral Service L	icensee,							E JOHNSO	N FUN	ERAL I	HOME.	P.A.
Hope	LA N	· Hul			21 LO					SON, M		286	1
23a. Part1. Enter t shock, or hea mmediate Cause disease or condition esulting in death)	(Final	a	caused the deceach line.	CANC		of dying	g, such as	cardiac (or respiratory arm	est,			imate Between and Death
Sequentially list co any, leading to in ause. Enter Under ause (Dissass or	onditions, nmediate arlying	b. Due to	(or as a conse	quence of):									
hat initiated events esulting in death)	S	c	(or as a conse	quence of:									
			(4									
		d					-						-
FEMALE: 3b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?		oirth 2 Fe nant at time of	tal death 3 □	Ectopic pre Other (spe						Date of deli- Month	very Day	Year
art II. Other signi	ficant condition	ns contributing to d	eath but not re	sulting in the ur	iderlying ca	use give	n in Part I			oacco use co			of death?
									24a. Was a autops perform	y ned?	o. Were aut prior to co death? 1 \(\text{Yes}	ompletion	ngs available of cause of

Physician /Medical Examiner

> Examiner After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit

Physician/Medical Be Completed by Medical Certification: To

IF FEMALE: 23b. Was dece Part II. Other sid

1 - For State Registrar

examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 - Homicide

29a. Certifier (Check only one)

25. Was case referred to medical

1 Yes 2 No

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel" or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: A filled in by the

10

The law requires that the death certificate be executed

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALIEN MAHMOD 2300 DAMEY LAWER RD, TICKNIUM MD 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature 29b. Signature and title of certifie

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 28c. Injury at Work? 28b. Time of М

1 ☐ Yes 2 ☐ No

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 No

28d. Describe how injury occurred

1 ☐ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MAR 0 1 2005

Steens D.

			1 - For State Registrar	State	of Maryland		rtment of F			giene 0 0 5 Reg. No.	06731
	Physicia		1. Decedent's Name (First, Middle	, Last) Shir	·ley Wa	lter	s – War	dell	2. Date of Dea Month Feb		3. Time of Death 12:15рм
	/Medic Examin		4a. Facility Name (If not institution,	-	ımber)		4b. City, Town, o	r Location of Death		4c. County of Deat	h
			4 Fitzgera					imore		Baltim	
	Funeral Director		212-62-4170	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. las 51	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar	7, Year) 7 1953 MAr	nplace (State or Foreign unity) Yland
Park	*		Usual Residence of Decedent 10a. State 10b. County		10c, City, 1	Town or Loc	cation				10d. Inside City Limits
1	sho s	ō	MD Balti	more	,	Esse					1 ☐ Yes 2 ☐ No
4	28a-	Director	10e. Street and Number			155	10f. Zip Code			10g. Citizen of What Co	untry?
4	3a or	<u> </u>	917 Garden D	rive			100	221		USA	,
1	ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. W	_l_	dispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		
	point. Tages I laint and Mental Hygiene. Incomment is the state of the	by Fur	1 ☐ Never Married	Armed F ed 1 ☐ Yes If Yes, G Year or I	2⊠ No ive		Yes, specify Cuba	an, Mexican, Puerti Specify:	o Rican, etc.)	Specify: Wh	
	atura		15. Decedent	's Education	1	16a. Deced	ent's Usual Occup	ation		16b. Kind of Business/	ndustry
1 2	Medi	Completed	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	(Give k life. D	kind of work done OO NOT use retired	during most of wor d)	king		,
4	giene ar tha	ĕ	12th	College	(1-401 54)	Maı	nager			Packag:	ing
3	al Hy f other	Be	17. Father's Name (First, Middle, I	_ast)				18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
À	d Menta	101	Stanley Wa			10h Mailine	a Address (Street		ey Dill	worth r, City or Town, State, 2	"- Codo)
2 3	th an		Michelle Cav		aughter						ip Code)
ָר נֿ	Heal Heal tem 2		20a. Method of Disposition	ey / u	20b. Plac	e of Dispos	ition (Name of		Date	DIE MD 20c. Location - City or	Town, State
2	y or o		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp.				atory or other place vCremat	ory 2/2	1/05	Baltimor	
	Depertme Importan eny injuri		21. Signature of Funeral Service I		11		Name and Addre	ess of Facility Co	nnellv	FuneralHo	meofEssex
1	10 = 5 8		23a. Part1. Enter the disease, or	1 Con	mell caused the death	4		Mace Av	e. Bai	timore MD	21221 Approximate
	hysician /Medical xaminer		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	each line.	refa		e Col			Interval Between Onset and Death IS Month
6	physicien and sthe burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequen						
.c.	The first program of swellight is settliffed in a state of the electric description of the electric description. To the Funerel Director: After this certificate has been signed by the eltending phy completely filled in by the funeral director, page 2 should be deteched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 movfts? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	1 Live	utcome of pregnanc birth 2 □ Fetal de nant at time of deat nown	eath 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year
,	signed be del	by	Part II. Other significant conditio	ns contributing to o	death but not resulti	ng in the un	derlying cause giv	ren in Part I.	A. I	bacco use contribute to es 2 No 3 Pro	
	has been sign	Completed							24a. Was a autops perform	sv prior to d	topsy findings available ompletion of cause of
ָ כ	licete ha	CO	25.11						1 ☐ Yes	2☐No 1☐Yes	21116
	th. :: After this certific e funeral director,	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending investig	28a. Date (Mor	Inpatient 2 EF of Injury 26 ofth, Day Year)	VOutpatient Bb. Time of Injury	28c. Injur Wor	er: 4 Nursing H		ence 6 X Other (Spec ow injury occurred	Daughters mE
	efter death Director:	ertification;	3 Suicide 6 Could n 4 Homicide determi	nod 286. Plac	e of Injury - At home ling, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	within 24 hours of the Funerei I completely filled	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	Examiner: On the b	e best of my knowled basis of examination oner stated.	edge, death n and/or inv	occurred at the tir estigation, in my o	me, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
1	ithin o th omply	Me M	29b. Signature and title of certifier				29c. Licens	e number	2	29d. Date signed (Month	, Day, Year)
,	- s = ō		> Sum	an Ka	am, o		D5	7703		2/25/05	
	1		30. Name and address of person of SUMAN RAD	. 3333	N CAI	VER		E107	BALTIN	NORE, M.	D 21018
	Sta Registr	200	31. Date filed (Month, Day, Year) MAR 0 1	2005	egistrar's Signat	Sp	refer	,,,,			

	1- For State of Ma Registrar	ryland / Department of Health and M Certificate of Death	ental Hygiene Reg. No. 005	06732
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) A. A. Facility Name (If not institution, give street and number)	WITHERSPOON 4b. City, Town, or Location of Death	2. Date of Death Month Day Ye Fabruary 24 300 4c. County of D	5 1430 M
Funeral Director	ST. AGNES HOSE	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	RE .	N/A Birthplace (State or Foreign Country) OUTH CAROLINA
death with the Maryland ma 23a or 28a-1 show trings the rediffed at near Director		10c. City, Town or Location BALTIMOA 10f. Zip Code	RE CITY 10g. Chizen of What	10d. Inside City Limits 1 X Yes 2 □ No
atter death with the Ma or Itema 23a or 28a-1 s rult wr marst be notified / Funeral Director	3200 CLIFTON F 11. Marital Status 12. Was Decedent El Armed Forces?	VENUE 2/2/ ver in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	city Yes or No- 14. Race - A	Merican Indian,
d 2 should be filed within 72 hours after th and Mental Hygiene. 77 is marked other than "natural", or its traumatic evant, the Middled Exercitiva To Be Completed by Fui	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2⊠ No Specify:	Specify:	BLACK
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Middle Exercit withing the notified at once. To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	TOW TRUCK DRI 18. Mother's Name		EMPLOYED
and 2 should be ealth and Mente n 27 is marked the traumatice.	DAVID 19a. Informant's Name/Relationship (Type, Print) BELINDA WITHERSPOON (WI)	THERSPOON ROSA 19b. Mailing Address (Street and Number or Rura FE) 3200 CLIFTON AVE	I Route Number, City or Town, Stat	
permit. Pages 1 and 2 Deportment of Health Important: if itam 27 i any injury or other tra once.	20a. Method of Disposition 1 ÄBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) WOODLAWN (EMETERY 13-0)	20c. Location - City 2-05 WOODLAN	WN MARYLANS
permit. Depart Import any inj	21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the part of the part o	the death. Do not enter the mode of dying, such as cardiac of	ROWN TR · FUN NAVE · BALTO , . r respiratory alrest,	140, 21217 Approximate
Physician /Medical Examiner	Lype	consequence of):		Interval Between Onset and Death
physician and sthe burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):		
e attending ad for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3 Ectopic pregnancy	23d. Date of Month	delivery Day Year
been signed by should be deta	Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death? Probably 4 Donknown
siction: The law requires that the certificate has been signed by th rector, page 2 should be detache be an applean by Physical By Physical By Physica			1- Yes 2 No 1 1-1	autopsy findings available to completion of cause of es 2 No
After this funeral d	1 ☐ Yes 2 ☑ No ☐ Hospital: 1 ☑ Inpatien		_Ccheck only one) ne 5 Residence 6 Other (Sed. Describe how injury occurred	Specify)
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	(Specify)	28f. Location (Street and Number or City or Town, State)	
To the Hospital Within 24 hours a To tha Funaral I completely filled Medical Ce	29a. Certiflier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner state. 29b. Signature and title of certiflier	29c License number	ed at the time, date and place, and d	due to the cause(s)
3 - 3	30. Name and address of person who completed cause of declarations of the state of	m, In . D. Doo4964 ath (Item 23a) (Type, Print)	2/25/0	5
$\overline{}$	WILLIAM J. HICK	EN. W.D STAGNES LOSE	BALTIMERE M	1 21929

DHMH 17 Rev 1/2001

MAR 0 1 2005 James 15 19

ORIGINAL

		•	FOI	artment of Health and Mental Hy	rgiene Reg. No.2 0 0 5	06733
	Physici /Medic		1. Decedent's Name (First, Middle, Last) 2ALPH CLYDE WILL	2. Date of De Mogth	Day Year	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel If Under 1 Year If Under 24 Hrs. 8, Date of Bir	4c. County of Deal Prince (George's
	Funeral Director		5. Social Security Number 6. Sex 190-14-5325 0. Sex 1 XX 2 F 80 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Month, Day) Hours Min. Jan 15,	ay, Year) 9. Bin Co 1925 PA	thplace (State or Foreign ountry) A
	a-f show	ctor	10a. State 10b. County 10c. City, Town or Let MD Howard Laurel	ocation		10d. Inside City Limits 1 ☐ Yes 2☐No
	with the	Dire	10e. Street and Number 10634 Hesperian Drive	10f. Zip Code 20723	10g. Citizen of What Co	ountry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked othar than "natural", or Itams 23a or 28a-f show othar traumatic avant, The Medical Existing final traumatic avant, The Medical Existing final traumatic avant, The Medical Existing final traumatic avant, The Medical Existing final fin	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2XXMarried 1XXes 2 No 1942	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX o Specify:	0- 14. Race - Ame Black, Whit	
21215-0036	within 72 hou iene. Than "natura Ta Medicul E	Completed	(Specify only highest grade completed) (Give life.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business	
.z pı	filed with If Hygiene. other ther	Be Co	17. Father's Name (First, Middle, Last)	r/Operator 18. Mother's Name (First, Middle	Jewelry S o, Maiden Sumame)	store
Maryland	2 should be and Mental I s marked o	ToE	Sevellon Wilcox	Olive Kuhn	Other Transport	T- 0- 4-1
	1 and 2 st Health and tem 27 is n			ing Address <i>(Street and Numbe</i> r or Rural Route <i>Numb</i> 34 Hesperian Drive Laure		
Baltimore,	0 0		1X Mourial 2 Cremation 3 Hemoval from State (ematory or other place)	20c. Location - City or Crownsville	
Balt	permit. Pag Department Important: I any injury o			2 Name and Address of Facility Donaldson Funeral Home, F 313 Talbott Avenue Laure		20707
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ster the mode of dying, such as cardiac or respiratory a SyNNOWE-W COECU NUCCHOU	WEV MONIA	Approximate Interval Between Onset and Death
0,	s be executed sician and s burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. The to (or as a consequence of):	FAIWRE		iodays.
09289	ficate by physic as the br	edicai	Ca GCCCIBIT	OS LLATURY		- Hyj
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of del Month	livery Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the conditions.	underlying cause given in Part I. 23e. Did t	tobacco use contribute to Yes 2 No 3 ☐ Pr	o the cause of death?
al Record		Completed	DISTURBINE URUPA	24a. Was auto, perfc 1 — Yes	ormed? death?	utopsy findings available completion of cause of
Vital	s certif	To Be	25. Was case referred to medical examiner? 1 Yes Hospital: 1 papatient 2 ER/Outpatie	26. Place of Death (Check only of ont 3 DOA Other: 4 Nursing Home 5 Resi		cify)
on of	F F ta		27. Manner of Death 12. Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		how injury occurred	
Division	or Attan	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		(Street and Number or Ri wn, State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: Sompletely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the time,	date and place, and due	e to the cause(s)
	To tha comple	×	296. Signature and interactifier	D 19 252	29d. Date signed (Mont	h, Day, Year) 26-05 ^
	01//		ROBERTU A DEPETRIS MI	14300 GALLANTOX LA	#122 Box	UKHDIO715
	Sta Regist		31. Date filed MAR Dry. Year 2005 . Registrar's Signature	nde /		

			For State Registrar	State of	Marylan	d / Depa		t of H	ealth a		ental Hy		005	06734
/1	ysicia Medic	al -	1. Decedent's Name (First, Middle Laurtt.	a .	4			Illia			2. Date of Dea Month	Day 2	4 2005	3. Time of Death 8:15 AN
	amine eral ctor		4a. Facility Name (If not institution Ja HNS Hopkin 5. Social Security Number 237 98 2377	5 HOSPITAL	7. Age (In yrs.	last birthday) 45 Yrs.	If Under	3 al 1	Hours	e P4 Hrs. 8 Min.	3. Date of Birt (Month, Da)	h v, Year)	N/ 9. Birth	
Maryland	Medat		Usual Residence of Decedent 10a. State 10b. County MD	N/A		y, Town or Lo	cation							10d. Inside City Limits
ath with the	nat be not	Funeral Director	10e. Street and Number 1727 E. OLIVER				10f. Zip	13				U.	izen of What Co	
.UU35 hours after death with the Maryland turel', or Items 23a or 28a-f show	ğ	by	11. Marital Status 1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Decer Armed For 1 Yes If Yes, Give Year or Da	ces? 2 [X No e		Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Amer Black, White Specify: BL	
within 72 ene.	the Medica	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 12th	t's Education st grade completed) College (1-	4or 5+)	(Give	DO NOT us	k done d	lurina most	of working			ind of Business/l $F_ullet \& G$	ndustry
aryland 2 should be filed nd Mental Hygid	netic event.	ge .	17. Father's Name (First, Middle, EARL WILLIAMS	·		20. 11.77			ORETH	IA HE	First, Middle,			
Ballimore, Mar permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m	r treu		19a. Informant's Name/Relations OUEEN PEARSON (2 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☐ Other (S	AUNT) 3 □Removal fr©in S	itate c	1706 SPlace of Disposementery, cres	SHERM esition (Name matory or of ON CEN	OD I	AVE I	ALTI Da ARCH	MORE, te 5, 200	MARY 20c. Lo		239 Fown, State
331		- 51	21. Signature at Funeral Service 23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final		2 0	h. Do not en	112 E.	PRI	ESTON g, such as c	STRE ardiac or	ET BAL	FIMO		NERAL HOME YLAND 2121 Approximate Interval Between Onset and Death
9 %	iner incal	cal Examiner	disease or condition resulting in death) Sequentially list conditions, Tany, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dive to (c	or as a consequence or a consequence or a consequence or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a conse	whose of): Valuence of):	infe		disco	ise				2 weeks 8 years
Hecords, P.O. Box 68 The law requires that the death certifical tensions been signed by the attending ph	detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pro					4	23d. Date of delin	very Day Year
rdS, P. quires that t an signed by	pe q	þ	Part II. Other significant condition	ons contributing to de	ath but not res	ulting in the u	ndertying ca	ause give	n in Part I.			bacco u		the cause of death?
	page 2	Completed					· · · · · · · · · · · · · · · · · · ·					sy med? No	prior to co	opsy findings available ompletion of cause of
	director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	patient 2	ER/Outpatier	t 3□ DO	A Othe			Check only o		S □Other (Spec	ihr)
ON O	funeral	Certification; T	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	28a. Date o (Month	f Injury n, Day Year)	28b. Time o Injury	f 21	8c. Injury Work 1 🗌 Y		28	ld. Describe h	ow injur	y occurred	
		II Certifi	4 Homicide determ	ined 286. Place	of Injury - At hogg, etc. (Specif	y) 			o date and		City or Tow	n, State)	ral Route Number,
DI) To the Hospital or within 24 hours afte To the Funerel Dir	mpletely	Medical		Examiner: On the ba and mann	sis of examina		vestigation,		inion, death		at the time, o	ate and		to the cause(s)
	_	_	· Mrsac	lyster	n	MD		RE:	5-00			F	ebruan	y 26 2005
	り		30. Name and address of person Brady Stein,	who completed cause 601 North (a of death (Item	123a) (Type, Street	Print) Bal	time	re	Mar	yland	. 2	-1287	
Re	Sta egistr	ar	31. Date filed (Month, Day, Year)	who completed cause 601 North (2005	ngistrar's Signa	ture A	porti	ì						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:10 p M February 26,2005 Samuel L. Walters /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 5,1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F Maryland 214-24-2889 76 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 No Maryland Baltimore Timonium Directo 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 12261 Roundwood Road 21093 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WⅢII Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify White 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier US PostalService 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Is marked o William Walters Ruby Batee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parkton, Maryland 21120 Cheryl Bianco / Daughter 19823 York Road item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
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once. 1 XBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 3/4/05 Baltimore, Maryland 21. Signame of Fonery Service Icens 22. Name and Address of Facility 1050York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 an 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ieregn son cular discuse Jears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Alsheimer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate **Division of Vital** Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence ADOther (Specify) 10 1 ☐ Yes 2 M No this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Felowary 27 2005 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATURE NO 21204

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** M Annie 3:45p Feb 21, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2501 Violet Avenue Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 ☑ F Yrs. Director 217-22-7634 Apr 2, 1929 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "neturel", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 2501 Violet Ave 903 N 21215 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status o filed within 72 hours after de Hygiene.
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other then "neturel", or Item Black, White, etc. ☐Yes 2☐No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 →Widowed 4 □ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Woodhome Country Club Skill Worker 12 shoutd be filed w h and Mental Hygier 7 le marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Montgomery Annie Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 le Richelle McCloud 6605 Kincheloe Avenue-#F Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If iter 1 XBurial 2 Cremation 3 Removal from State 02/28/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Arbutus Memorial Park 21. Signature of Funesal Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 Nes (1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypoxemya /Medical Due t **Examiner** Filmosis Pulmonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Probably 4 ☐ Unknown Completed ASTMA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 211 No Drabetes Division of Vital Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 22, 2005 D0035674 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1902 Northern PARKWAY Stute 201 Back md 21239 WANDER - Simmons - Clemmons MD 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/5 Derin G849 11/14/05 IT
State of Maryland / Department of Health and Mental Hygiene 1 = For State Registra Certificate of Death Reg. No. 2. Date of Death Day 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 22,2005 Cc. County of Death 10P M **Physician** Charles Gustavus Ziegler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 30 Itimore harlestown -atons ville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 2,1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Socurity Number 6 Sax **Funeral** Months 1⊠M 2□F Yrs. Pennsylvania 215-02-1815 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County r then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Catonsville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 U.S.A. 709 Maiden Choice Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 TWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Medical Veternarian treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 is marked ott jury or other treumatic even Ida Kaufman Gustavus A. Ziegler ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hanover, Maryland 21076 Kenneth C. Ziegler (Son) 1431 Boulder Lane 20c. Location - City or Town, State 20b. Place of Disposition /Name of 20a Method of Disposition Meadowridge Memorjal Park permit. Pages 1
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once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-25-2005 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licen Funeral Home of Catonsville, Inc. mondson Ave. Catonsville, MD 21228 Witzke Funeral Home 1630 Edmondson Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) theroscleratio **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed and r that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown 9 Unknown β 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 5 ☐ Residence 6 ☐ Other (Specify) 4 ☐ Nursing Home 2 ER/Outpatient 3 DOA 2 No 1 Inpatient Certification: To 1 Tes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a

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completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 01 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Maide Himore MD 21228 Choice Lane, 31. Date filed (Month, Day, egistrar's Signature Year State WAR 01 2005

Registrar

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	/Medical Examiner		resulting in death)		or as a conseq											
	Lxammer		Sequentially list conditions,	b. CER	EBRO	VASC	Cellt	TR.	Acc	1DC	NT			4	- WEEK	-5
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (o	or as a conseq	uence of):										
	ate be executed hysician and the burial-transit	cam	that initiated events resulting in death) Last	c	or as a conseq									_		
0220	cian a	E	, and the same of	Due to (o	or as a conseq	uence or):										
077	physicate to physical streets	dical	,	d						-						
Ú	- O G	Physician/Med	IF FEMALE:													
2	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	Ideath 3	Ectopic pr					2	3d. Date of Month	,	ay Year	
-	the deby the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□ Unknov	int at time of d wn	eath 5	Other (sp	ecify)					WOTE		u) / 02.	
ام ما ام	d by	Ph	Part II. Other significant condition:	e contribution to do	ath but not son	udina in the co			- i- D- 4 l		22a Did	tabaasa			cause of death?	
, c	res that signed t	by	Fait II. Other significant condition.	s contributing to dea	airi but not 195	ulling in the ur	idenying G	ause give	en in Pair i	•					oly 4 Unkno	
LRJ.	w require been sign	ted									, ,	195 2	3140 3	riobab	ny 4 DONANO	WII
111	e law has b	ple									24a. Was	DSV	24b. Were prior	autops to comp	y findings availa detion of cause of	ble of
BE		Completed									perfo 1 ☐ Yes	ormed? 2⊠No	death 1 □ Y	1? 'es 2)	⊠(No	
ROBE Vital Bo	Physician: this certifical ral director,	Be (25. Was case referred to medical examiner?								(Check only					
	physic this co	P	1 ☐ Yes 2 🕱 No			ER/Outpatien	t 3 🗆 DO	A Othe	er: 4 □ Nu	rsing Hon	ne 5□Resi	idence 6	Other (S	pecify)		
	Te Te	:io	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of (Month	f Injury , Day Year)	28b. Time of Injury	2	8c. Injury Work	at		8d. Describe					
NZ	lel or Attending s after death. al Director: After ed in by the fune	Certification:	2 Accident investigat				М	1 🗆 `	Yes 2 🗌	No						
Z	r Att	tilii.	3 ☐ Suicide 6 ☐ Could no determine	28e. Place C	of Injury - At he g, etc. (Specif	ome, farm, stre	eet, factory	, office		2	28f. Location (City or To	(Street and wn, State)	Number or	Rural F	Route Number,	
M	Hospitel or 14 hours afte Funerel Dire tely filled in t															
Q	10sp 4 hou rune ely fil	edical	(Check only 2 Medical Ex	Physician: To the bastaminer: On the bast	sis of examina	wledge, death	occurred a	at the tim	e, date an pinion, dea	d place, a	and due to the	cause(s) a	and manner	as state	ed. ne cause(s)	
J	the the	Medi	one)	and manne	er stated.											
	To To To To To To To To To To To To To T	1	29b. Signature and title of certifier	lah -		A1 -			number	,			signed (Mo			
		90	Colon	· · · ·	MEDIC	HL DOG	TOR	PI	160	(FEB	, 24	20	305	
	A /	7.11														
•	1/1		30. Name and address of person wh	no completed cause	of death (Iten	n 23a) (Type, I	Print)	,		_	h	~ 1	220			
179	1	ate	30. Name and address of person wt	o completed cause	of death (Item VEN) Istrar's Signa	1 23a) (Type, I	Print) BA	LTI.	mor	E,	MD	21	229			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #5 PER FH G841 3 Reziji(isate) Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:0 /Medical 4b. City, Town, or Location of Death Fecility Name (If rist institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. 214-50-2550 (In yrs. last birthday) 6. Sex Year 8. Date of Birth (Month, Day, Year, rthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 □ F Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 0 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden 19b. Mailing Address (Street and Number or Rural Route Number, City or item 27 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date Department of Important: If it is any injury or concept. 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 DRemoval from State 28/05 ⁴ 4 ☐ Donation 21. Signature of Funeral Service Licensee au Part 1. Enter the disease, com shock, or heart failure. List only complications that caused the death. Do not enter Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 4 Morus /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ⊅nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 You 24a. Was an autopsy 2[200 2000 1 Tes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔯 o Other: Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who com Place

State Registrar 31. Date filed (Month, Day, Year)

MAR 02

2005

James Alston 05-RPD

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)		•	- State Unpend Item 23	a,pt.II,27	per me	3841′3≃18 rtificate of l	-05 tas Death	ornarrry	Reg. No.2	5 06741
	D		1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	Physici: /Medic		JAMES ALSTON						ry 24, 20	05 1202 P M
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or			4c. County of I	Jeath
	Funeral		5810 Reisterstown 5. Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	Baltimo: If Under 1 Year	If Under 24 h	rs. 9 Date of Bir	th a	Birthplace (State or Foreign
2	Director		215-56-4084 XX	M 2□F 5:	2 Yrs.	Months Days	Hours M	01/1	7/1953 M	ARYLAND
)	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Maryi -f sho	to	MD N/A		BAL'	TIMORE (CITY			X Yes 2 □ No
	th the or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	ath wii	raic	3815 HILLSDALE				21207		USA	
21215-0036	s within 72 hours after death with the Maryland Jiene. r then "naturel", or items 23a or 28e-f show The Madical Exarchiser out the notified a	by Funeral	11. Marital Status 1 ▼ Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1XXes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Black, V	American Indian, White, etc. LACK
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade	ation completed)	(Give	dent's Usual Occup	during most of t	working	16b. Kind of Busin	ess/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) YEARS		00 NOT use retired ABILITY	d)		N/A	
d 2	Hyg Hyg ent,	a)	17. Father's Name (First, Middle, Last)	IEAND) DID.		18. Mother's h	Name (First, Middle		
<u>lan</u>	D ta D 💌	To B	JAMES C. ALSTON	, SR.			LOUI	SE GILC	HRIST	
Maryland	shand sand	ľ	19a. Informant's Name/Relationship (Typ			_			er, City or Town, Sta	
	1 an Heall em 2 thar		LOUISE ALSTON / 20a, Method of Disposition			osition (Name of	DALE K	Date Date	20c. Location - City	
nor	of of		Y Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State M	ARYLAN	D VETERA	ANS 3/	4/05	OWINGS	MILLS, MD
Baltimore,	permit. Page Department importent: it any injury o		21. Signature of Funeral Service Licenses	L.FOT	JAN 2	2. Name and Addre	ss of Facility	HOWELL 1	FUNERAL	HOME 21207
<u>~</u>	Per im B	(1)	1/ Winner	O. Cour	14 4	600 LIB	ERTY H	GHTS. A	VE., BAL	TIMORE, MD
			23a. Part Enter the Isease, or complic spock, or heart ailure. List only one	ations that caused the decause on each line.	ean. Do not ent	er the mode of dyin	ng, such as card	fiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immedia Cause (Final disea or condition resulting in death)	Athersclero Due to (or as a cons		diovascul	ar Dise	ase		
	Examiner		Sequentially list conditions b.	,						
	р <u>н</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Little funderlying Cause (Disease or injury that initiated events c.	Due to (or as a cons	sequence of):					
	be executed sician and burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):					
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89		edi	15.55.11.5							
Вох	ath cer tendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pre-1 ☐ Live birth 2 ☐ F	etal death 3[⊒Ectopic pregnancy	,		23d. Date of Month	f delivery Day Year
O.	at the dea by the ai	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	of death 5	Other (specify)				,
4	th de de	by Ph	Part II. Dther significant conditions cont	ributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
Records,	w raquiras baan sign should ba		Chronic Alcoholism	l .				1	Yes 2□No 3[Probably 4 Unknown
eco	e law re has beo	Completed						24a. Was	psy prior	e autopsy findings available to completion of cause of
ai R		Соп						1 X perio	ormed? deal	Yes 2□ No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	ospital: 1 Inpatient 2	ER/Outpatien	nt 3 DOA Oth		Death (Check only o		Specify) At Scene
of		 	27. Manner of Death	28a. Date of Injury (Month, Day Year		" 3 DOA	4 🗀 14013111		how injury occurred	Specify) 110 Security
ion	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(WORL), Day Year	Injury		Yes 2 □ No			
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factory, office		28f. Location (City or To		or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		29a. Certifier 1 ☐ Certifying Physi	cian: To the best of my	knowledge, deat	h occurred at the tir	me, date and pla	ace, and due to the	cause(s) and manne	er as stated.
	To the Hospitai within 24 hours of To the Funeral completely filled	edicai		er: On the basis of exam and manner stated.						
	To the To the Comp	ž	29b. Signature and title of certifier	1.1.1	1 -	29c. Licens			29d. Date signed (M	
,				rah A			CME		February	24, 2005
			30. Name and address of person who cor	npleted cause of death (I	item 23a) (Type,	^{Print)} 111 P	enn Str	eet Balt	imore, Ma	ryland 21201
l	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 2 2	32. Registrar's Sig	gnature	Soule				

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of He	ealth and Mental Hygiene

		•	1 - State Registrar		Cei	rtificate of	Death		Res	g. No.	105	06/4	12
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Death Month	Day	Year	3. Time of De	ath
	Physici /Medic		Eugene		Allen				FEBRUARY	Ž6,	2005	11:20 E	₽.М
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town,				4c. Cou	nty of Death		
			VA MARYLAND HEA				ERRY I				CECIL		
	Funeral Director		5. Social Security Number 213–18–1441	1 X M 2□ F	(In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days		Min,	8. Date of Birth (Month, Day, 1	Year) -20	9. Birthp Coul	olace (State or Fo	oreign
	and *		Usual Residence of Decedent 10a, State 10b. County		10c. City, Town or Lo	ocation					1	10d. Inside City L	imits
	Aaryli I sho	ō	_									1 [XYes 2[
	28a-	Director	Md. NA		Dai	timore			10	a Citizen	of What Cou	ntn/2	
	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examinations to rodified at		4804 Greencres			212				USA	A	14,0	
	er de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of If Yes, specify Cut	Hispanic Ori ban, Mexicar	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White,		
215-0036	ours aft	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	nied 1 2 Yes 2 □ No If Yes, Give Year or Dates:	0	1□Yes 2X No	Specify:			Spe	cify: Bl	ack	
2	72 h 'natu	Completed	15. Deceden (Specify only highes	t's Education st grade completed)	(Give	dent's Usual Occu kind of work done	during mos	st of workin	ng 16	6b. Kind of	Business/In	dustry	
2	within 72 ene. than "na	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retire	ed)			CC	71		
121	filed w Hygier Sther th		8th grade	1	Cu	stodial	10 Marks	- d- N	(Fire A Adiabate AA	GSZ			
Maryland	b d la b	To Be	17. Father's Name (First, Middle, John		Allen			iola	(First, Middle, Ma		Smith		
an L	0 60 00 00		19a. Informant's Name/Relations	hip (Type, Print)					Route Number, (-	Code)	
	C = 01 L		Egene Allen, J	Jr. Son	_		Haven		Baltimo	re, l	Md. 2	1128	
altimore,	of Hee	3	20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ice)	Da	ate 20	oc. Locatio	n - City or To	wn, State	
Ē	Pages ment of ent: if it ury or o		4 □ Donation 5 □ Other (S		Md. Nati	onal Mem	ı = i	3-4-	·05 <u>r</u>	aure	l, Md.		
3all	permit. Pages Department of importent: If it any injury or o		21. Signature of Funeral Service	Licensee	22	2. Name and Addr	ess of Facilit	ty	Baltim			21202	
m —	₽ □ = 9	NI 10	Bemand &	Junayn		March F.			1101 E.		th Ave	•	
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to	the death. Do not ent e.	er the mode of dy	ing, such as	cardiac or	respiratory arres	it,		Approximate interval Betwee	
0	Pnysician	8 1	Immediate Cause (Final disease or condition		RY ARTERY							Onset and Deat UNKNOWN	
12	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):								
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	and I-tran	Examin	that initiated events resulting in death) Last		ES MELLITU consequence of):	S TYPE I	1			_			
68760,	ertificate be executed ding physician and se as the burial-transit				,								
28/	ficate phys s the	Medical		0.									
ŏ			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						23d. [Date of delive	erv	
n	0 0 0	Physician	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at to]Ectopic pregnand] Other <i>(specify)</i> _	;y				Month	Ďay Year	r
J O	The law requires that the de- tte has been signed by the a bage 2 should be detached for	hys	9 🗆 Unknown	9 Onknown					_				-
	as tha	by F	Part II. Other significant condition			nderlying cause gr	ven in Part I.		23e. Did toba	cco use co	ontribute to th	ne cause of death	h?
g	w require been si should t	ted	ATRIAL FIBRILL	ATION, BLADDE	ER CANCER				1 🗌 Yes	2 🗆 No	3 🗌 Prob	ably 4XDUnkn	nown
Kecords,	law r as be	Completed							24a. Was an autopsy	241	b. Were auto	psy findings avai	lable e of
_		Com							performe	d? I No	death?	mpletion of cause 2□ No	
<u> </u>	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Table 18 A				of Death	(Check only one)				
of Vital	Physiclan: r this certificaral director.	ဥ	1 ☐ Yes 2X No	Hospital: XXInpatien		IL SU DOA		_	ie 5 ☐ Residend			r)	
	afte and	lon	27. Manner of Death 1 X Natural 5 ☐ Pendin		Year) 28b. Time of Injury	Wo			8d. Describe how	injury occ	urred		
<u>s</u>	Attendideath.	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	not be	n. At home form et-		Yes 2		Rf Location (Stre	at and Nur	mbor or Our	I Davida Mumbas	
DIVISION	i or A	Certification:	4 ☐ Homicide determ	building, etc.	ry - At home, farm, str. (Specify)	eet, ractory, office		20	8f. Location (Stre City or Town,	State)	nber or Hura	i Houte Number.	,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical C	29a. Certifier Check only one) Certifyin 2 Medical	ng Physician: To the best of Examiner: On the basis of e and manner state	examination and/or inv	n occurred at the ti vestigation, in my	me, date an opinion, dea	nd place, ar	nd due to the cau d at the time, date	se(s) and a	manner as st e, and due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier		1	29c. Licen	se number		29d	l. Date sigr	ned (Month.	Day, Year)	
			Shen 9	* Hast	amie M		D246	548	ন	EBRIIZ	ARY 27	, 2005	
	, M		30. Name and address of person	who completed cause of de	ath (Item 23a) (Type,	Print)	22.30					, 2000	
_	Le71		SHER A. HASHMI	, M.D., VA M	ARYLAND HE	ALTH CAR	E SYST	rem,	PERRY PO	INT,	MD 219	902	
	Sta	- 4	31. Date filed (Month, Day, Year) MAR 0 2 20	32. Registrar	r's Signature	W.							
	Registr	ar	MAR 0 2 20	U) MARIE	20 July								

			1 - For State Registrar	State of Maryland / Dep		Mental Hygie		5 0671.
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) ILIA 4a. Facility Name (If not institution, give s NORTHWEST HOSPITA)	L CENTER	ALPERT 4b. City, Town, or Location of Deal RANDALLSTOWN	2. Date of Death Month FEB. 28	Day Year 2005 4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 212-37-9755	M 2 F 7. Age (In yrs. last birthday, 73 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		(ear) 9. Bin	thplace (State or Foreig ountry) UKRAINE
	the Maryland 28a-f show	rector	MD 10b. County BALTIMOI	10c. City, Town or L RE BALTIMO		100	Citizen of What C	10d. Inside City Limit
36	De lied within 72 hours after death with the Maryland Hygiene. Sid other than "natural", or items 23e or 28e-f show event, the Medical Erain incrning to notified at	by Funeral Olrector	6908 MARSUE DRIVE		21215 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 No Specify:		U.S.A. 14. Race - Am. Black, Whi Specify: WH	erican Indian, te, etc.
Maryland 21215-0036	tiled within 72 hou Hygiene. other than "natura ont, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Dece (Give Completed) 16a. Dece (If the College (1-4or 5+)	ident's Usual Occupation Is kind of work done during most of wo DO NDT use retired)	rking	b. Kind of Business	
ıryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the M	To Be	17. Father's Name (First, Middle, Last) LEV 19a. Informant's Name/Relationship (Ty)	ALPER		me (First, Middle, Ma	,	YUFEST
more,	nit. Pages 1 and artment of Health ortant: If Item 27 injury or other tr e.		MAIA ALPERT / WIFE 20a. Method of Disposition 1	6908 20b. Place of Disp. cemetery, cre BALTIMORE	MARSUE DRIVE APT position (Name of matory or other place)	T. 1-C BA Date 200 L/2005 R	LTIMORE, c. Location - City or EISTERSTO	MD 21215 Town, State
	ale de executed and limpe in special in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limpe in the burial-transit and limbe in the burial-transit and	cal Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C.	CONGESTIVE HEART Due to (or as a consequence of): ISCHEMIC CARDIOMY Due to (or as a consequence of): CORONARY HEART DI	FAILURE OPTHY			MD 21208 Approximate Interval Between Onset and Death SUDDEN
0 VOO .	death certhic e attending pl d for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
necolds, r	rife faw requires trat trie tte has been signed by th page 2 should be detache	by	Part II. Other significant conditions cond CHRONIC RENAL		nderlying cause given in Part I.		.,	the cause of death?
		e Completed	25. Was case referred to medical			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 ☐ No
	After this funeral di	ToB	examiner?	ospital: 1 Inpatient 2 X ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	ot 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how i		pify)
		Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	,	28f. Location (Stree City or Town, S	tate)	
	within 24 hours after to the Funeral Direction	Medical	29a. Certifier (Check only one) 2 Medical Examinone)	cian: To the best of my knowledge, deater: On the basis of examination and/or in are and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	rred at the time, date	a(s) and manner as and place, and due Date signed (Montl	to the cause(s)
2	1	/	30. Name and address of per in who con	npleted cause of death (Item 23a) Type,	D15533		RCH 1, 200	
	Sta Registr		CHRYSOLOGUE GAKUBA 31. Date filed (Month, Day, Year)	2 RESERVOIR C	IRCLE, PIKESVILLE	, MD 21208	3	

			1 - For State Registrar	State of	Marylan		artment of F rtificate of				gien Reg. N	Z 11115	06744
	Physici	an	1. Decedent's Name (First, Middle	, Last)			.			2. Date of Dea			3. Time of Death
	/Medi	cal	Violet		Bak	ley_				Februa	ry	24, 2005	
	Examir	ier	4a. Facility Name (If not institution Clinton Nursin	-	r o r)		4b. City, Town, o		of Death			County of Deal Prince (
	Funeral		Social Security Number	6. Sex 7.	Age (In yrs. Is	ast birthday)	If Under 1 Year	If Under		8. Date of Birt	h	9. Birt	holace (State or Foreign
	Director		136-54-3112	1 □ M 2 🛣 F	96	Yrs.	Months Days	Hours	Min.	(Month, Da Aug. 1() , rear	908 Cam	den, NJ
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	a-fsh	ctor	Maryland Prince	e George's	C1:	inton							1 ☐ Yes 2 📉 No
	or 28	Directo	10e. Street and Number				10f. Zip Code				10 g . Ci	tizen of What Co	ountry?
	s 23a		9211 Steward L		E	2 10	20735				U.S		
(0	r Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decede Armed Force ed 1 ☐ Yes 2	es?	5. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexican	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, White	
8	ours a	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 💢 No	Specify:				Specify: Wh	ite
5-0	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-1 show ant, the Madical Externitist in ust be notified at	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usual Occup	durina most	t of working	9	16b. K	(ind of Business/	Industry
12	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4	or 5+)		00 NOT use retired omemaker	1)			Ora	n Home	
פ	il Hygi other	Be C	17. Father's Name (First, Middle, L	ast)			Omemaret	18. Mothe	r's Name (First, Middle,			
/lar	Menta Menta Arkad Arice	To B	Howard Bosticl	K				Mary	Stre	eet			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationsh				ng Address (Street						
e)	1 and Health am 27 ther t		Robert N. Blal	cley (Son)	20b. Pla		Lakeview sition (Name of	Dr.,	Falls	The state of the s	_		
JOE L	ages ent of ht: If it		1 Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp		ate Ce	metery, cren	natory or other plac morial Pa		3-4-0			nsauken	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 show any injury or other traumatic evant, the Marical Extending to must be notified at once.		21. Signature Funeral Service L		Всег								
<u> </u>	8958		Jennis	Villm	un		. Name and Addres		700 Audu	S. Whi	ţe J 0	Horse P: 8106	ike
Ħ.			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cau only one cause on eac	sed the death. h line.	. Do not ente	er the mode of dyin	g, such as	cardiac or i	respiratory arr	est,		Approximate Interval Between
	Pnysician /Medical	i y	Immediate Cause (Final disease or condition resulting in death)	a	Conje as a confeque	stive He	Pail Faller	r I					Onset and Death
k	Examiner			Due to (or	as a confequ	ence of):	ahet di	0.	144	.1.	st		
	D =	ner	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that introduced to the control of	b. Due to (or	as a sunsequi	erice of).	obstadia	100	" MCCCCI	VILe	-		
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseque	Hy Po	Thyraid						
8760,	icate be executed physician and s the burial-transit	a E		Due to (or	as a conseque	ence or):	Denentin						
687	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d		enju	Penanti						
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnan 2 □ Fetal o		Ectopic pregnancy					23d. Date of deliv	very
0	at the dea by the at tached fo	Physiclan/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		t at time of dea		Other (specify)					Month	Day Year
<u>.</u>	that the ed by detac	Ph	Part II. Other significant condition	ns contributing to death	n but not resul	ting in the un	nderiving cause give	en in Part I.		23e. Did tol	pacco u	use contribute to	the cause of death?
Records,	w requires that been signed b should be deta	ed by	aste f								es 2		bably 4 dunknown
ဝင္တ	law rea	Completed								24a. Wasa		24b. Were aut	opsy findings available
		Com								autops perforr		death?	ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho			Check only on			
7	Phys or this oral dii	. To	1 Tes 2 No 27. Manner of Death	28a. Date of li	atient 2 E	R/Outpatient 28b. Time of	and the second second	4 P 19ur		5 Reside		Other (Speci	fy)
Ö	ath. r: After ne funer	atloi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, i	Day Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ N			,=.	,	
Division of	al or Attending F s after death. I Director: After I d in by the funera	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place of	Injury - At horr etc. (Specify)	ne, farm, stre	eet, factory, office		28f	Location (St. City or Town	reet an	d Number or Rur	al Route Number,
_	Hospital or 24 hours afte Funeral Dir tely filled in	O	29a. Certifier 1 Certifying	Physician Table ha	at at any tra-	1. 1. 1. 11							
	To tha Hos within 24 hc To the Fun completely	Medical	(Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	i or examinatio	nedge, death on and/or inv	estigation, in my op	e, date and inion, death	l place, and h occurred	at the time, da	tuse(s) ate and	and manner as s place, and due t	stated. o the cause(s)
	To tha Hospital within 24 hours a To the Funeral I completely filled	M	29b. Signature and title of certifier				29c. License			2		e signed (Month,	Day, Year)
P		2	K. D		Mn			2564	10		2	125/05	
	00		30. Name and address of person w K. Davachi, M.		f death (Item 2		_{rint)} 106 I rvi n	ø St.	NW W	lashino	ton	, DC	
	Sta	е	Of Bata Glad Ad att Bank A		strar's Signatu			0 50.	2111 /			,	
	Registr		MAR 02	2005 32. Real	see .	H. A.	bark						

		•	1 - For State Registrar	State of Man		artment of H			ene200	5 06745
	Dharini		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day \	3. Time of Death
	Physici /Medic		WILLIAM		BENC	(-1		FEBRUAT		
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of	
			NORTHWEST	HUSPITAL			If Under 24 Hrs.			TIMORE
	Funeral Director		5. Social Security Number 6. S X	□X M 2□ F	n yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		7			reb. 5,	1928 1	Pennsylvania
	yland		10a. State 10b. County	10	Oc. City, Town or Lo					10d. Inside City Limits
	B Mar	ctor	MD Baltime	ore	Randa11	Lstown				1 ☐ Yes ¾☐ √No
	or 28	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wh	at Country?
	eth w	rall	8309 Lages I				244		U.S.	
	er de Itams	nne	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	rs aft	by Funeral	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	XIXYes 2 □ No If Yes, Give Year or Dates: K	orea	1□Yes 🏋 🏋 No	Specify:		Specify:	White
21215-0036	ilied within 72 hours after deeth with the Maryland Hygiene. other than "natural", or items 23s or 28s-f show shift the Medical Evaning trust be notified at		15. Decedent's Ed	ducation	16a, Dece	dent's Usual Occupa	ation	16	b. Kind of Busi	
215	hin 7.	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worki ()	ing		
21	d with	mo:	9		Log	gistics	Enginee	r	Westir	ighouse
ng	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	uiden Sumame)	
yla	Ment Arked arked	70	Michael Ben				Cathe		Unknow	
Maryland	2 short and lam		19a. Informant's Name/Relationship (ng Address (Street a				
	l and lealth im 27 har ti		Mary T. Bench		20b. Place of Dispo	Lages La				
Baltimore,	ges It of H		20a. Method of Disposition 1 Burial XXCremation 3	Removal from State	cemetery, crei	matory or other plac	e)			ty or Town, State
ţ	t. Pa rtmer rtant:		* 4 □ Donation 5 □ Other (Specify 21. Signatur F eral Service Licenters)							nore, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ampointent: If item 27 is marked other than "natural", or other traumatic event, the Medical Examinar manifes rodified at once.		21. Signatur Priveral Service Lice	m						Chapel P.A. Mills,MD2111
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not ent	er the mode of dying	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Me-	tastati	diseas	to the	lary.	n yc	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c		diseas)		
	Examine	_	Sequentially list conditions,	b. Due to (or as a c		of th	1,ver			6 months
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury							
	xecul and	xar	that initiated events resulting in death) Last	C. Due to (or as a c		incer				
8760,	ate be executed hysicien and the burial-transit	dical		d						
89	death certificate be executed e attending physicien and of for use as the burial-transit	edic		. 0.					1	
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [Testania aragnana.			23d. Date	of delivery
		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Ectopic pregnancy Other (specify)			Month	Day Year
P.0.	law requires that the de as been signed by the a r 2 should be detached f	hys	9 🗆 Unknown	9□ Unknown						
	as this gned be de	by F	Part II. Other significant conditions o	ontributing to death but r	ot resulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
ord	w require been sign	ted						1 Tes	2 □ No 3	Probably 4 Unknown
Records,	ne law r has be ge 2 sh	Completed						24a. Was an autopsy	24b. We	re autopsy findings available or to completion of cause of
<u>س</u>	ate pa	Con						performe 1 ☐ Yes 2 2		ith? I Yes 22 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					(Check only one)		
) t	Phyaician: r this certific ral director,	To	1 ☐ Yes 2√2 No	Hospital:	2 ER/Outpatier			me 5 Residence		(Specify)
n c	ing F	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	Work	ς?	28d. Describe how	injury occurred	
Si	Attending ir death. ector: After by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not be		- At home form etc		Yes 2□No	28f Location (Stre	et and Number	or Rural Route Number,
Division of Vital	i Çite	Certification:	4 Homicide determined	building, etc. (Specify)	eet, factory, office	'	City or Town,		or ridial riodic rediniber,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier IX Certifying Ph	ysician: To the best of n	ny knowledge, deat	h occurred at the tim	ne, date and place	and due to the cau	se(s) and mann	er as stated.
	e Hos 24 h a Fur letely	Medical	(Check only 2 Medical Exan	niner: On the basis of ex and manner stated	amination and/or in	vestigation, in my or	oinion, death occurr	ed at the time, date	and place, and	due to the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (i	Month, Day, Year)
,	O		Orrotan	Mo.		7.1	0059736	6	house	94 2005°
1	DN		30. Name and address of person who		h (Item 23a) (Type,				1	34 2005
1	V '		DEBURAH WATS		NURTHNE	ST HUP	TAL 5	54 DI OLD	COURT	C:40
	Sta	0.14	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	H. Show				
	Registr	ar	MAR	0 2 2005	Electrica.	M. Anous				

			For State Registrar	State	of Maryland / i	Depai			lental Hy		05	06746
			Decedent's Name (First, Middle, L.	ast)					2. Date of Dea			3. Time of Death
	Physici /Medio Examin	cal	HARRIET 4a. Facility Name (If not institution, g	MARIE ive street and n	BEASLEY		4b. City, Town, or	r Location of Death	Month Februa		Year 2005 ty of Death	2:40 a ^M
			GILCHRIST HOSPI	CE CENT	ER		TOWSO)NI				E CO
	Funeral			Sex	7. Age (In yrs. last bi		If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	TIMOR. 9. Birthp	place (State or Foreign
0	Director		219-34-1625	1 ☐ M 2X F	67	Yrs.	Months Days	Hours Min.	(Month, Day AUG 18	, <i>Year)</i> 1937		YLAND
30	p. ,		Usual Residence of Decedent								1 1111	TEMP
N R	Maryland -f show	_	10a. State 10b. County		10c. City, Tow	vn or Loca	ation				1	0d. Inside City Limits
73	the Ma	cto		ORD CO	E	DGEW	OOD					1 ☐ Yes 2 ☑ No
00 12	or 2	Director	10e. Street and Number				10f. Zip Code			log. Citizen of	What Cour	itry?
20	death with ms 23a or		1971 BROOKSID	E DR.			210	40		U.S.	Α.	
	er de tems	Funeral	11. Marital Status	Armed F		13. Wa	as Decedent of Hi	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
36	ours after death with the Marylar raf', or Items 23a or 28a-f show Eraminer must be notiff of a	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, G	: 2 XO No ≧ive		Yes 2∕OXNo	Specify:		Speci	h	
2-003	72 hours "natural", olesi Eva			Year or								ACK
7 5		Completed	15. Decedent's (Specify only highest g	rade completed	<i>i)</i>	Give kil ife DC	nt's Usual Occupa nd of work done of NDT use retired	ation during most of worki. ()	ing	16b. Kind of E	lusiness/inc	dustry
2121	e filed within il Hygiene. other than "	щ	Elementary/Secondary (0-12)	College	(1-4or 5+)	D AS		,	i.	DEDOCT	TITON (OF GARG
	filed Hygi other ant, II	ပိ	17. Father's Name (First, Middle, Las	st)	, A	מא עו	51.	18. Mother's Name				OF CARS
RPNE	ould be Mental arked o	ToB	RUSSELL C MYI	ZDC				DORA V.		Waldon Calma	,,,,	
Harriand	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relationship		196	o. Mailing	Address (Street a	and Number or Rura		City or Town	State Zin	Code
	# 2 m		Valerie M. Brown					ath Ct.,				
Baltimore,	ges 1 and t of Health If item 27 or othar tr		20a. Method of Disposition	i/ Daugiii	20b. Place o	f Disposit	ion (Name of	D	-	20c. Location		
200	ages ant of it: If i		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other Spec		n State	-	tory or other place	· !			ony or re	
Baltimore	permit. Pages of Department of History In Itemportant: If ite any injury or ot once.	11	21. Signature of Fund 1 Service List	(1y) (500)	SHARP		EET U.M.			CHASE,		
(Z) 88	Depa Impo any ir	1 10	1//	Draw	le	32.	L S PHIL	ADELPHIA	BLVD.,	ABERDE	-HARF EN, MI	FORD, P.A. D 21001
			23a. Part1. Inter the disease, or conshock, brieart failure. List only Immediate Cause (Final	nplications that y one cause on	caused the death. Do each line.	not enter	the mode of dying	g, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Inysician /Medical		disease or condition resulting in death)	a			MICEL	2				year
	Examiner		1	Due to	o (or as a consequence	of):						0
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consequence	of):					-	
	unsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or many that initiated events									
	be executed sician and burial-transit	Xa	resulting in death) Last	c. Due to	(or as a consequence	of):					-	
760,	be icia	cal		d								
89	ificate g phys as the			0.								
Box 68	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregnancy	_				23d Da	ite of deliver	0/
m	death e atte d for	cla	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Preg	birth 2 ☐ Fetal death mant at time of death		ctopic pregnancy other (specify)			1		Day Year
P.O.	by the detached	hys	9 Unknown	9□ Unki	nown				-			
, i	res that igned b	by P	Part II. Other significant conditions	contributing to	death but not resulting in	n the unde	erlying cause give	n in Part I.	23e. Did tot	acco use cont	ribute to the	e cause of death?
Ď.	w require been sig should b								1 □ Ye	s 2 No	3 🗌 Proba	ably 4 Unknown
ဝ	aw re	Completed							24a. Was a	24b.	Were autoc	ssy findings available
a a	The tare has page 2	mo							autops perforn	y ned?	prior to com death?	npletion of cause of
ta	an: tiffica tor, p	BeC	25. Was case referred to medical					26. Place of Death	1 Yes 2		1 ☐ Yes 2	2∐ No
>	ysician; is certific director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 ER/Ou	itnatient	3□ DOA Othe	r: 4 Nursing Hon			as (Specify	Jasa A.
0	ding Ph h. After th funeral	2	27. Manner of Death		of Injury 28b. T	Time of	28c. Injury Work	at 2	28d. Describe ho	w injury occur	red	1, Ospice
io	feath. tor: Aft the fur	ate	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		nin, Day rear)	njury		es 2 □No				
Division of Vital Records,	Arte er de recto by th	ific	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Plac	e of Injury - At home, fall ling, etc. (Specify)	ırm, street	, factory, office	2	8f. Location (Str	eet and Numb	er or Rural	Route Number.
۵	s after or salter Certification:	Tomodo	Dulle	ung, etc. (Specify)				City or Town	, State)			
3		Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the t	e best of my knowledge basis of examination and oner stated.	death odd/or inves	ccurred at the time tigation, in my op	e, date and place, a inion, death occurre	and due to the ca	use(s) and ma ito and place,	inner as sta and due to	ited. the cause(s)
- 1	Mithin To th Compl	Me	29b. Signature and title of certifier		2		29c. License	number	29	d. Date signe	d (Month, E	lay, Year)
	1		> 9/ H. K.	_ /Li	le mo)	0.25	205		-		
	1"	-	30. Name and address of person who	completed cau	se of death (Item 23a) ((Type, Pri	nt)		/	0.7.07	77-	1
	1		W.A.Riley	6.6	3/nc 6.	701	N. Ch	205 enles St	- Ba	lto. n	rd 2	1204
	Stat Registra		31. Date filed (Month, Day, Year) / MAR 0 2 2	005	legistrar's Signature	Apre	de					

			For State Registrar	State of Mar		artment of He		Mental Hygie	000	
	Physici /Medi		1. Decedent's Name (First, Middle, Las John Anthony Barar	noski				2. Date of Death Month February	Day Yeer 23, 2005	
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L			4c. County of Dea	ath
			Frederick Villa 5. Social Security Number 6. Se		me In yrs. last birthday)	If Under 1 Year	Catonsv If Under 24 Hrs.			Ltimore inhplace (State or Foreign
	Funeral Director		212-03-2732	ØM 2□F	84 Yrs.	Months Days	Hours Min.	Jul 8, 19	920 Ma	ary Land
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-fah	tor	MD Baltin	nore		Catonsvi]	lle			1 ☐ Yes 27 No
	th the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	country?
	23a ust b	ral	1021 Grovehill Ro	ad		21	228	J	Jnited St	ates
980	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or items 23a or 28a-f ahow event, the Modical Examinar must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1\(\sum_\) Yes 2 \(\sum_\) No If Yes, Give Year or Dates:	10/30/ I	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (S Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	ithin 72 ho ie. ian "natur Modical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ring most of wor	king	. Kind of Business	
2	filed wi Hygien other th			731		Navigator			J.S. Air	Firce
/land	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M.	To Be	17. Father's Name (First, Middle, Last) Frank Amos Baranos	ski		1		ne <i>(Fir</i> st, Middle, Maid atilda Kol	,	
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic en Once.		19a. Informant's Name/Relationship (7) Margaret E. Barane	•				ral Route Number, Ci butus, MD		Zip Code)
Baltimore,	ages 1 a nt of Hea . If item or othe		20a. Method of Disposition	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)	1	Date 20c	. Location - City o	
Ę	artmer artmer ortant injury	1	4 □ Dollation 5 □ Other (Specify 21. Signature: Funeral Service Licen			rematory,		rose Funer	Baltimore	
Ba	Depar Impor any ir	(De Mermer	10121	11 1111 201			g Rd., Arb		
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or companies, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a c	estati e		-	an Cer		Approximate Interval Between Onset and Death
68760,	death certificate be executed eattending physician and of for use as the burial-transit	edical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
.O. Box	ch the	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
rds, P		by	Part II. Other significant conditions of	ontributing to death but i	not resulting in the u	nderlying cause given	în Part I.			o the cause of death?
Vital Records,	The law requires ate has been sign page 2 should be	Completed	Hypo	xemia				24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
ta		Φ	25. Was case referred to medical			2	26. Place of Dea	1 Yes 2. th (Check only one)	10 10 10	2 110
	S S	To B	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Other:	Nursing H	ome 5 Residence	6 Other (Spe	ecify)
o no	Jing After fune		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of tnjury	Work?	s 2 No	28d. Describe how in	ntury occurred	
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or A ate)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral is completely filled	edical (29a. Certifier Check only one)	ysician: To the best of r iner: On the basis of ex and manner state	(amination and/or in	n occurred at the time, restigation, in my opin	, date and place, nion, death occur	and due to the cause rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	AHerdin	X	29c. License r			Date signed (Mon	
11	JAV		Melerex	thy	zivien	1 2) 5 (1705		2/24	105
7	J		Rodolfo E. Fey	revel #	MD 40	5 Freder	ich Ke	#162	Cathon	105
	Sta		31. Date filed (Month, Day, and 2	2005 32. A	Sionature	grade				

State Registrar 3350WILKERS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COMINO

32. Registrar's Signature

ISENT ZER 31. Date filed (Month, Day, Year) 0006

AVE

BALTIMORE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 5:00A M Briscoe 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 7808 Hidden Creek Way Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗗 F Yrs. Director 82 Feb. 8,1923 New York 577-36-3061 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, the Madical Exeminer must be notilized at 1 ☐ Yes 2 ☐ No Directo Baltimore Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7808 Hidden Creek Way death Funeral 21226 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or itel 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ₩idowed 4 Divorced American Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N'A 12 Director Senior Citizens Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Davis Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1262 Hamlin Street N.E. Washington D.C. 20017 Bernard P. Davis (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of I-dent: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 2/24/05 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma 5monts /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Oulpatient 3 DOA Other: 2 10 ours after death.

eral Director: After this of filled in by the funeral dire To 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Tes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; To the Hospital or Attending 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 1 Cortifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hours To the Fune completely file Medical 29b. Signature and title of certifier Affen 29c. License number 29d. Date signed (Month, Day, Year) D44973 February 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GURMEET-5'-SAWHNET , 202, GLENBURNIE 325 HOSPITAL PRIVE MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAR 02 2005 Darves J. Spele Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of Ma	arylan		rtment o		nd Me	_	giene Reg. No.			06750
	Physicia	an	Decedent's Name (First, Middle, La							. Date of De	ath	. Ye	يجرا1	3. Time of Death
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	Examin	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LOCH RAVEN V.A. HOSPITAL CENTER BALTIMORE CITY N/A											
	Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 2	4 Hrs. g Min.	Date of Bird (Month, Da 05/17	h y, Year)	9.1	Birthpla Count	ace (State or Foreign
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		iner	11. Marital Status	12. Was Decedent E Armed Forces?				of Hispanic Orig Cuban, Mexican,	in? (Speci Puerto Ri			14. Race - A Black, W		
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			12TH 17. Father's Name (First, Middle, Last,)		NURS	ING T	1	's Name (First, Middle,		S. HC	SP.	ITAL
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lary			19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Str	eet and Number					a, Zip (^{Code)} 21133
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nor			1 X Burial 2 Cremation 3		MAŔ	YĽXNĎ	vatory or other VET (EM						
Baltimore,			CARRISON FOREST 3/8/05 OWINGS MILLS, MD 21. Signature of Operal Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207											
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of Vi			examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 Inpatie	ent 2 🗆 I	ER/Outpatien	3 □ DOA	Other		5 Resid		6 □Other (S	pecify)	
o u			27. Manuer of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?					28d. Describe how injury occurred					
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Div			4 Homicide	building, etc. (Specify)					City or Town, State)					
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
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	010		Jeorge C 30. Name and address of person who Seorge E. W	completed cause of d	eath (Item	3900 3900	Loch K	Raven E	Bouler	ravd,	Bat	timor.	2 M	D. 21218
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			For State Registrar	State of Marylan		artment o				ene 200	5 06751	
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	Examin	er	2301 Brown Station				er Marl			Prince	George's	
	Funeral Director		5. Social Security Number 6. Sex 213-36-8890	M 2□F 7. Age (<i>In yr</i> s. 67	last birthday) Yrs.	If Under 1 Ye Months Da		Min. J	Date of Birth (Month, Day, an 4, 1	938 M	Birthplece (State or Foreign Country) aryland	
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	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Arked other than "natural", or Itama 23a or 28e-f show arked other than "natural", or Itamia be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 (Z)Yes 2 □ No If Yes, Give Year or Dates: 156-	ŀ	Was Decedent If Yes, specify (1 ☐ Yes 2 🔯			y Yes or No- can, etc.)		merican Indian, /hite, etc. white	
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	os 1 and 2 of Health a Item 27 la other tra		Sharon Baker/spous		Name and Address of the Owner,			n Road Dat		Marlboro		
	50 to 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re • 4 ☒ Donation 5 ☐ Other (Specify)			sition (Name o natory or other		Dat		20c. Location - City	or rown, State	
Balt	permit. Page Department Important: If any Injury or		21. Signal of Funeral Types License	11 Jell	Ba	altimor	e. MD	21201		Baltimor	e Street	
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Records, P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of Month	23d. Date of delivery Month Day Year	
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•			1 Jehnah a. T	rassur, n	7/)	Da	05249	6 (r	ND)	2/23/3	2005	
			30. Name and address of person who co	mpleted cause of death (Iter	1 23a) (Type,	Print) 0753 F	aus R	d Ste	145,L	uthervil	6 MJ 21093	
,	Sta Regist	ate rar	31. Date tiled (Month, Day, Year)	32. Registrar's Signa	ature Ana	(h)						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ... 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 1355 Margare Baummer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Merci Baltimore City

Richbolace (State or Foreign timore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Hours Min Days 1 ☐ M 2 🔀 F Director 214-26-6944 76 09/26/1928 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral', or items 23a or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Upper Falls 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8328 Bradshaw Road Funeral 21156 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced er than "natural", White ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaking Own Home other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jiny or other traumatic event <u>once.</u> Be <u>Mark Leo Muller</u> Anna Fitzpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis W. Baummer (husband) P.O. Box 49 - Upper Falls, Maryland 21156

Method of Disposition

Visual 2 Cremation 3 Removal from State

Visual 2 Cremation 3 Removal from State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Stephen Ch. Cem. 103/02/2005 Bradshaw, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland aa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** one week /Medical Due to or as a consequence of) Strauss Synowome Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Straws histor 2 No 3 Probably 4 Unknown Completed 24b: Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? I Director: After the in by the funera Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by within 24 hours To the Funeral

Medical

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

David

E. Baranano 32. Registrar Signature 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

7469

1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month LIC February 21 2005 0044A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Hours Months Days 1 MM 2 □ F 12 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f shov must be notified at 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status r than "natural", or Iten 1 Yes 2 No
If Yes, Give
Year or Dates: 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 1 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ##g. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) s 1 and 2 should be filed with file and Mental Hygien tem 27 Ia marked other th traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be Chinor L. Collick SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 Is ury or othar trai Apt. 202 But ND 21239 20b. Place of Disposition (Name Baltimore, 20a. Method of Disposition 20c. Location City or Town, State 1 KBurial 2 ☐ Cremation Department of Important: If any injury or 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Load OR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ng, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician Multiple zunshot /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, for y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed 1 Z Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 XYes 2 □ No 28a. Date of Injury (Month, ay Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 □ Yes 2 🕅 No 12:19A Subject 2/21/05 2 Accident Diractor: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 600 N Lakewood 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lakewood Ave Local Baltmore To the Hospital within 24 hours a To the Funeral D HUI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME February 21, 2005 who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 AN MA 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 02

2005

			1- State of Maryland / Dep	partment of Health and Nertificate of Death		ene2 0 0 5	06754
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> JOSEPH STEVE CYKIE	eta .	2. Date of Death Month FEBRUARY	Day Year 27 2005	3. Time of Death 2:50 A M
	Examin		4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF NORTH ARUNDEL	4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Dear	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 219-18-4337 12 M 2 F 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Dec. 26,	9. Bin Co 1924 Ma	thplace (State or Foreign buntry) ryland
	show	٥٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a-f	Directo	Maryland Anne Arundel Baltimo	10f. Zip Code	10g	. Citizen of What Co	
	s 23a	rai	8041 Highpoint Road	21226	* 14	U.S.A.	Constant
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, It is Marical Examinational by notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🗷 No Specify:	Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0	ithin 72 ho ne. nan "natur nan "natur	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king	Anne Arus	ndel Co.
d 21	filed w Hygier other th		12 () 17. Father's Name (First, Middle, Last)	Inspector 18. Mother's Name	e (First, Middle, Ma		ublic Works
Maryland	should be ind Mental I marked o	To Be	Anthony Cykieta	Stell		czynski	
Mar				ling Address (Street and Number or Run Highpoint Road, E			
ore,	ges 1 and it of Health if Item 27 or other ti		20a Method of Disposition 20b. Place of Disp			c. Location - City or	
altimore,	permit. Pages Department of Important: if It any injury or o		`4 Donation 5 Other (Specify) Holy Gro			altimore,	Maryland
Ba	Depa Impo any i		The Samuel 3	2. Name and Address <i>o</i> f Facility IcCully—Polyniak Fu 204 Mountain Road,	ineral Hon , Pasadena	ne P.A. a, Marylan	nd 21122
Į,			23a. Part1. Enter the disease, or complications that caused the death. Do not en hook, or heart failure. List only one cause on each line.			t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Infinediate Cause (Final disease or condition resulting in death) a	diae Arrhyths	wa.		5-00MH
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	cuted nd ransit	Examiner	Cause Unsease or injury that initiated events c.				
760,	ate be executed hysician and the burial-transit	icai Ex	resulting in death) Last Due to (or as a consequence of):				
.O. Box 68	ath certific attending p for use as	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date <i>o</i> f deli Month	ivery Day Year
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/ita		Be	25. Was case referred to medical examiner?		h (Check only one)		
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Divisi	orite i Dire	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Ru State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral (completely filled	edical C	29a. Certifier (Check only one) 1 **DCertifying Physicien: To the best of my knowledge, dea (Check only one) 1 **Medical Examiner: On the basis of examination and/or in and manner stated.				
1	To the within:	M	29b. Signature and title of certifier Molfary	29c. License number	29d.	Date signed (Month	h, Day, Year)
8	24/1		30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number D ~ 42521 Print) 325 (LOSPITAL MEN BUR	DRIVE	Aut E 2	208
-	UN		DR JCHANES 31. Date filed (Month, Day, Year) 32. Registrar's Signature	STEN BUR	NECMO	21061	
	Sta Registr		MAR 0 2 2005 Here It Apr	ule			

			1 - For State Registrer	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of		Mental Hy	/giene	06755
	Physic		1. Decedent's Name (First, Middle, Last)	Co	ok		2. Date of D		
	/Medi Examir		4a. Facility Name (If not institution, give	kins Ho	sPital	4b, City, Town,	or Location of Dea		4c. County of De	eath
l	Funeral Director		5. Social Security Number 246-40-7508 Usual Residence of Decedent	x 7. Ag	ge (In yrs. last birthday, Yrs.	Months Day			nth ay, Year) 9. E -33	lirthplace (State or Foreign Country) Md.
	show show	2	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	ith the Ma or 28a-f	rect	Md. NA 10e. Street and Number		Ba	ltimore 10f.Zip Code			10g. Citizen of What	1 X Yes 2 □ No
	23s o	ralD	1500 Montmor Cou	rt		212	:17		USA	,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel', or items 23e or 28a-f show any injury or other treumetic event. The Madical Exam per nursible invitible at any injury or other treumetic event.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	f Hispanic Origin? (S iban, Mexican, Puel o <i>Specify:</i>	Specify Yes or No to Rican, etc.)	o- 14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. Black
21215-0036	within 72 ho lene. t hen "natu he Medical	ompletec	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 5th grade	cation e completed) College (1-4or 5	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of wo red)	orking	16b. Kind of Busines	ss/Industry
	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, In Me	To Be C	17. Father's Name (First, Middle, Last) John	Coo	k		18. Mother's Na	me (First, Middle	, Maiden Surname) Davis	
Maryland	and 2 should ealth and Men n 27 Is marke ler treumetic		19a. Informant's Name/Relationship (T) Virginia Minor-Co	rpe, Print)	19b. Maili			ural Route Numb	er, City or Town, State	, Zip Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr. pnce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo	osition (Name of matory or other pl	ace)	Date	20c. Location - City of Randallst	
Balti	permit. Pages Department of Importent: If it any injury or conce.		21. Signature of Funeral Service Licens Barmand D Q		22	Name and Add			altimore, M E. North Av	id. 21202
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a		er the mode of dy			arrest,	Approximate Interval Between Onset and Death 2 how
8760,		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	·	a consequence of):					7 days
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rds, P.	w requires that been signed should be det		Part II. Other significant conditions con Esophageal	tributing to death bu		nderlying cause g	iven in Part I.		obacco use contribute Yes 2□No 3	to the cause of death? Probably 4 Unknown
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Division	al or Atte s after de al Directo ed in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ury - At home, farm, str c. (Specify)	et, factory, office		28f. Location (S City or Tov	Street and Number or F vn, State)	lural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and/or inv	occurred at the trestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	M			se number		29d. Date signed (Mon	
	3		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type,	Print) Towe	er 110 De	sctor's fe Street	Lounge et Baltimo	4.MD 21287
	Sta Registr	te	31. Date filed (Month, Day, Year) MAR 0 2 2005	2. Registra	ur's Signature	E)				

			1 - For State Registrar		State of	Marylan		artmen rtificat				lental F	Hygie Reg.	00	0.5	06	756
	D)		1. Decedent's Name (First	, Middle, Last	')							2. Date of Month		Day	Year	3. Time o	f Death
	Physic /Medi		Edwin	Perry	y	Crar	idell					Feb.	22.		T ear	3:30	рМ
	Examir		4a. Facility Name (If not in	stitution, give	street and num	ber)		4b. City,	Town, or	Location	of Death			4c. County	of Death	-4	
			Country Ho	me Ass	isted I	iving		Н	arwo	od				Anne	Arui	nde1	
	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day Ye	ear)	9. Birth	place (State ontry)	or Foreign
п	Director		578-07-24	50 -	ØM 2□F	98	Yrs.		Duyo			May 2	25,1	906		land	
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an	ld be ental ked c ev	To Be	Edwin G. C	rande1	1					Ls	wini	a Whi	++	acton			
Maryland	2 should be f and Mental I is marked of sumatic eve	-	19a. Informant's Name/Re	elationship (T)	rpe, Print)		19b. Mailir	na Address	(Street a					ity or Town,	State. Zir.	Code)	
Ž	and 2 ealth a n 27 is		Edwin Cran	de11 (Son)									ng, MD			
ē,	- T T =		20a. Method of Disposition	<u> </u>		20b. P	Place of Dispo emetery, crei					ate		Location -			
9	0 0		1 🔀 Burial 2 ☐ Cren `4 ☐ Donation 5 ☐ C			late	 Jame: 			1	1261	2005	т.	. 1 . 1) (T)		
Baltimore,			21. Signature of Funeral S			- 50								thian	, MD		
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			23a. Part1. Enter the dise	ase, or compl	lications that ca	used the deatl	h. Do not ent	er the mod	e of dying	Ly A	cardiac o	r respirator	tapo. v arrest.	lis, N	10 21	Approximat	.0
	Physician		shock, or heart failur Immediate Cause (Final	e. List only o	ne cause on ea	ch line.	for									Interval Bet Onset and I	
	/Medical		disease or condition resulting in death)		a. Due to (c	as a conseq	uence of):									100	9
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n	ding Pt The After th funeral	ino ino	27. Manner of Death 1 Sanatural 5	Pending	28a. Date of (Mo⊓th	Injury , Day Year)	28b. Time of Injury	21	Bc. Injury Work	at	2	28d. Describ	e how i	njury occurre	ed		
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Division of Vital Records,	or Atten efter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place o	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str	eet, factory	, office		2	28f. Location City or 1	n (Street Town, Si	t and Numbe tate)	er or Rura	l Route Num	ber,
	urs e		-		1						- 1						
	To the Hospital or At within 24 hours effer of To the Funeral Directompletely filled in by	edical	29a. Certifier 154 C (Check only 2 M one)	ertifying Phys edical Exami	sician: To the t ner: On the bas	sis of examinat	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the	e, date	e(s) and ma and place, a	nner as st ind due to	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title, of	certifier	and manne			290	License	number			29d	Date signed	/Month	Day Year)	
	8 4 8 4	7	Lahon	(11)	Men	ine no	CD			362	46		1	-	/		
ì	1		7 JUELLY		1					(*			2/2	1	/	
	0		30. Name an address of p	levine i	mpleted cause	or death (Item	1 23a) (Type,	Print)	00 5	F. 1.	-2 K	male	6.6	Port	MD	7-17	1.5-
	Sta		31. Date filed (Month, Day		32 4 Re	gistrar's Signa	ture A	- au		~ ~		1 JUNCIO	402 8		1		
44	Registi		,	2 200	5 Star	of death (Item 6 Ham gistrar's Signa	X Apr	and the									

			1 - For State Registrar	State of	Marylar	-	artment of H				-20	05	06757
			negistrar Decedent's Name (First, Middle, La	ist)			tinoate or i	Dealin		Date of Death	g. No U	00	3. Time of Death
	Physici		Michael Franci	s Corkra	n				F	Month ebruary	Day 22, 2	Year 2005	6:30p M
	/Medic Examin		4a. Facility Name (If not institution, gire				4b. City, Town, or	r Location of		ebi dai y	4c. Count		0.300
h	ZX	Ϋ.	1806 Belle Avenu	e			Dundalk				Bali	timore	2
	Funeral				. Age (In yrs.	last birthday)	If Under 1 Year	If Under Hours	24 Hrs. 8. Min.	Date of Birth		9. Birtho	lace (State or Foreign
L	Director		216-40-0917	1 2 M 2 □ F	62	Yrs.	Months Days	Hours	No.	(Month, Day,)	1942	Mary	land
	pur 😮		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	antion						04 1-14-05-11-5
	lanyla aho	ក					Cation					1	0d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	Maryland Baltimo:	re	Dune	dalk	10f. Zip Code			10	- Citiese of	14/5-14 (2-1	
	with Ba or						2122	2			g. Citizen of nited		
	leath ns 23	era	1806 Belle Aven	12. Was Deced	ent Ever in U	l.S. 13 V			gin? (Specify			ce - Americ	
(0	r Iter	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forc	es? □ No		Was Decedent of H f Yes, specify Cuba	ın, Mexicar	n, Puerto Rica	an, etc.)	Bla	ick, White,	etc.
8	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes 2 ☐ No	Specify:			Specif	^{fy:} Whit	te
21215-0036	be filled within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23s or 28s-f ahow event. The Madical Examiner must be matified at	Completed	15. Decedent's E (Specify only highest gr				dent's Usual Occup- kind of work done		t of working	16	6b. Kind of B	usiness/Inc	dustry
2	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. I	DO NOT use retired	1)	. o. woming			0	
7	ygier ygier her th		12			Machi	nist				Westva		·
and	be fi	Be	17. Father's Name (First, Middle, Last	"						irst, Middle, Ma		ne)	
Maryland	hould d Mer narke	우	Connor Lewis 19a. Informant's Name/Relationship	(Time Print)		105 14-16-	ng Address (Street			e Leidl		O	
Z	d 2 s th an t7 is r traur		Daria Corkran (w			1	Belle Av			alk, Ma			- 1
ē,	Hea Hea tem		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	I	Date		Oc. Location		
9	Pages ent of ht: If i		1 🖾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci		ate St.	Andre	matory or other place W. Russian	(e))2/26/2	2005 D	undall	z Mos	rsv1 and
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event. The Madical Examiner must be multilled at once.		21. Signalu e of Funeral Service Lice	• •	OLII	22	Cemetery . Name and Addres	s of Facilit	y				
m	Depar Impo		Hohn Carton	44		B:	radley-As 134 Willo	hton- w Spr	-Matthe	ews Fun oad Ba	eral l Itimo:	iome, re. MI	lnc. 21222
			23a. Part1. Enter the disease, or com	plications that cau	sed the deat								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	6	linh	laston	(n	00.444	Can	.)		,	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consec		19 (3)	14 (4)	CETT	Cer			lears.
	LAAIIIIIEI		Sequentially list conditions.	b									
	ed sit	ulne	cause. Enter Underlying Cause (Disease or injury	Due to (or	ลิธิ ลิ ธิบกระบ	uance or);							
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consec	uence of):					_	-	
8760,	icate be executed physician and s the burial-transit	dlcal		d									
68	ificate g phy as the	edic		_ u.									
Вох	h cert endin use	M/u	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		T-+i				23d. Da	ite of deliver	ry
B	that the death certificed by the attending to detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of c]Ectopic pregnancy] Other (specify)				Mo	onth	Day Year
P.O.	at the by the	Phys	9 🗆 Unknown										
	res tha	by	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the ur	nderlying cause give	en in Part I.		_			e cause of death?
orc	w requir	ted			-					1 🗆 Yes	2 No	3 Proba	ably 4 Unknown
Records,	2 2 2	ompleted								24a. Was an autopsy	1	prior to con	osy findings available apletion of cause of
E E		Cor								performe 1 □ Yes 3√2		death?	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	20		heck only one)			
o		. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 □ Inp	-	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 LI NU		5 Resident)
Division	Attending Ph r death. ector: After th by the funeral	tion	1 Patural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	Work	<br Yes 2 □ h		D0001.50 1.0W	injury coour	100	
VİSİ	or Attendated death Director:	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of			eet, factory, office					er or Rural	Route Number,
ā	tal or A s after al Direc ed in by	Certification;	4 - Homoles	building	, etc. (Specil	у)				City or Town,	Siate)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exa	hysician: To the b	est of my kno	wledge, death	occurred at the time	ne, date and	d place, and	due to the cau	se(s) and ma	anner as sta	ated.
	the hin 24 the F	Med	one)	and manne	r stated.								
1	To co		29b. Signature and title of certifier		11		29c. License				I. Date signe		-
,	0		30. Name and address over son who	completed cause) ,	Doo .	5474	19	6	2/24	105	
V	`		2112 Dunda	IW Ai	A E	(1ype,	dolle M	Λ ¹ 2	125				
	🤛 s. Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	iture	A Carre	V ¥ .	-				
	Registr	ar	WAR 02	2005	all ser	St 1	dalle M						

DHMH 17 Rev 1/2001

		1	For State Registrer	State of M	arylan		artment tificate			ind M	lental	Hygier	20	05	116	758
	Physicia		1. Decedent's Name (First, Middle, La Frances L. DeMasi	,							Mont		Day	Year	3. Time of	
	/Medic Examin	al					4b. City, T	Town, or	Location of	f Death	02	27	4c. County		3:45	р м
	LAdillii	e.	⁴ a Facility Name (If not institution, given the Charlestown Retine 1707 MaidenChoice 1	rement Cen Lane	ter				svil				Balt		9	
	Funeral Director		5. Social Security Number 6. S 226-10-7456 Usual Residence of Decedent		9 2	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date (Moni 05–2	of Birth th, Day, Ye 1-191	ar) 2	Cou	olace (State on ntry) ginia	or Foreign
	rytand ihow		10a. State 10b. County			y, Town or Lo									IOd. Inside Cit	
	he Ma 8e-f s	Director	MD Baltime	ore	Catc	nsvill									1 🗌 Yes	2 XNo
	with t	ă	10e. Street and Number 707 Maiden Choice	Lano			10f. Zip (.228					Citizen of V	What Cou	ntry?	
	death	Funeral	11. Marital Status	12. Was Decedent		S. 13. \	Was Decede		panic Orig	gin? (Spe	city Yes		14. Rac		can Indian,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23s or 28s-f show aumatic event, the Medical Exactionatic event, the Medical Exactionatics.	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			fYes,speci 1□Yes 2		Specify:	, Puerto	Rican, et	c.)		k, White, ,:Whit		
5-0	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupa k done di	tion uring most	of worki	ing	16b	. Kind of Bu	usiness/In	dustry	
7	iene.	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	Insped		a retired)				Ma	nufac	turi	ng	
힏		BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, N	fiddle, Maid	ten Suman	10)		
<u>X</u> ai	ould b Ments arked	20	Homer Landers						Gert							
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ed Bemis/Son	Type, Print)			Box 1							State, Zip	Code)	14
ē,	s 1 an f Heal Item 2 other		20a. Method of Disposition		20b. P	lace of Dispo					ate		. Location -	City or To	own, State	
altimore,	Page nent o int: If iry or	1	1 ☐ Burial 2 ②Cremation 3 ☐ Qonation 5 ☐ Other (Speci			view (3/1/	2005	Ва	ltimo	re, N	1D	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic es QRCS.	(21. Signature of Funeral Service Libe	DOD	Ru		Name and abrose 328 Su	Addres Fur 11phi	s of Facility neral ir Sp:	Hom ring	e, I	nc. Arbu	tus M	D 212	227	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each I	d the death ine.	n. Do not ent	er the mode	of dying	, such as	cardiac o	or respirat	tory arrest,			Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. acuto	12	AL									Onset and E	Beath
	/Medical Examiner		•	Due to (or as	a conseq	uence of):									9	
ķ,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clistate or injury	b. Due to (or as	a consequ	uence of):										
	ecuted and -transi	Examiner	that initiated events resulting in death) Last	c												
8760,	rcate be executed physician and s the burial-transit	cal E	Tooling it boding sales	Due to (or as	a consequ	uence or):										
687	ificate g phys as the	0		d		750										
Box .	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1☐Live birth 4☐Pregnant a 9☐Unknown	2 ☐ Feta	Ideath 3□	Ectopic pre Other (spe						23d. Dai Mo	te of delive	•	Year
P.O.	hat the ed by t detach		9 ☐ Unknown Part II. Other significent conditions		out not resi	ulting in the u	nderlying ca	IISA CIVA	n in Part I		23e	Did tobaco	o use cont	ribute to t	ne cause of de	leath?
Vital Records,	sign d be	Completed by	constid arter					g				1 ☐ Yes		3 ☐ Prob		Jnknown
eco	law requas been 2 should	plet		4							24a.	Was an autopsy	24b. \	Were auto	psy findings a	available ause of
E E	iiclen: The la certificate has rector, page 2	Con									10	performed	2 (death? □ Yes	2 No	
ĬŽ	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		5B/0		Othe	26. Place							
of	g Phys er this eral di	\vdash	27. Manner of Death	28a. Date of Inju	ury	28b. Time of		Bc. Injury Work	4 Nut				6 Oth		y)	
ion	Attending Firdeath, sector: After by the funera	atio	1 Natural 5 Pending investigation		ay rear)	Injury	М		? es 2□N	No						
Division	ol or Attenerater death	Certification:	3 ☐ Suicide 6 ☐ Could not 8 4 ☐ Homicide determined				eet, factory,	office		1		tion (Street or Town, St		er o <i>r Rur</i> a	al Route Numi	iber,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying P Certifying P	hysicien: To the best miner: On the basis of and manner s	of examina	wledge, death tion and/or in	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due t	o the cause time, date	e(s) and ma and place,	nner as s and due to	tated. the cause(s)	s)
	To the To the comp	Ž	29b. Signature and title of certifier				29c.	License	number			29d.	Date signe	d (Month,	Day, Year)	
1	111		mance	M		<u> </u>	0	30	989			Fel	ona	n ₁ i	27 20	205
Ų	γ		30. Name and Address of person who	completed cause of	death (Item	1 23a) (Type,	Print)	~ ^	haic	٦ ا	^	0-1		11	27 20 MD	
	1											- 4 % %				
	Sta	ite	31. Dadfiled (Month, Day, Year)	32. P gist	rar's Signa	iture	Mae		indic	× -	<u> </u>		or PA1	цφ	MD	

DHMH 17 Rev 1/2001

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			1 - State Registrer			Cei	rtificate	of L	Death	1		Reg. No	o.	U	1100
	Physici	an	Decedent's Name (First, Middle, L.	•						1	2. Date of D		ıy Year		ime of Death
	/Media		Jean Hunter De								Month	ু		5/10	; 15P M
	Examir	er	4a. Facility Name (If not institution, g ST-AGNES + UFALT)	ive street and num	ber)	AVE	4b. City, To					40	. County of Dea	th	
_									MIC				N/A		
	Funeral Director			Sex 1 □ M 2 X F	'. Age (In yrs. last l	Yrs.	If Under 1 Months 1	Days	If Under Hours	Min.	B. Date of B (Month, D	ay, Year	9. Bir	thplace (Sountry)	State or Foreign
Ь,			Usual Residence of Decedent		00				L	P	ec. 6	, 192	24	Main	e
	yland now		10a. State 10b. County	-	10c. City, To	wn or Lo	cation							10d. Ins	ide City Limits
	Mar.	ģ	MD Bal	timore			Arbu	itus	3					1 []Yes 2⊠No
	or 28	Director	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of What Co	untry?	
	ath with the Marylan 23a or 28a-f show ust be notified at	aiD	1111 Oakland Te	rrace Roa	ad			212	227			Un	nited St	ates	
	ems ems	Funerai	11. Marital Status	12. Was Deced	dent Ever in U.S.	13. \	Was Deceder f Yes, specify	nt of Hi	spanic Ori	igin? (Spec	ify Yes or N	0-	14. Race - Ame		ian,
36	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Acal Examiliter must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2	2 ∑ No	1	l □ Yes 2		Specify:		ouri, otc.)		Black, Whit	e, etc. Whi	te
Ö	hour tural	D D	3 Widowed 4 Divorced	Year or Da											
Maryland 21215-0036	ihin 72 ho e. en "natur Mooical	Completed	15. Decedent's I (Specify only highest g	rade completed)		(Give	lent's Usual (kind of work DO NOT use	done a	luring mos	it of working	7	16b. K	and of Business	Industry	
212	≥ 6 € 5	m o	Elementary/Secondary (0-12)	College (1-	4or 5+)		Secret						Educat	ion	
ğ	Hyg otha	BeC	17. Father's Name (First, Middle, Las	st)						er's Name (First, Middle	e, Maiden		1011	
ılar	Mental Mental arkad atic eve	ToE	Herbert Hunter							Augus	sta Go	ooin	1		
lan	and and sum	•	19a. Informant's Name/Relationship	(Type, Print)	19	9b. Mailin	g Address (S	Street a	nd Numbe				or Town, State,	Zip Code)	
	s 1 and 2 of Health item 27 other tra		Anthony Dellaveco	chia Hu	sband	1111	0akla	nd	Terra	ace Ro	d., Ar	butu	s, MD 2	1227	
ore	Jes 1 of H if ite		20a. Method of Disposition 1 ☐ Butial 2 ☐ Cremation 3	☐Removal from S	20b. Place	of Dispo:	sition <i>(Name</i> 1157 Cett	of	1	Da	te	20c. L	ocation - City or	Town, St	ate
Ë	. Pag tment tant: jury o		' 4 □ Donation 5 □ Other (Spec	eify)	@ Cro	wnsv	ille			3-3-20		Cro	wnsvill	e, M)
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature : Funeral Service Live	nsee	\$ 1/100	1/22	. Name and	Addres	s of Facilit	^{ty} Ambro	ose Fu	nera	1 Home,	Inc	
	40240		23a. Part1. Enter the disease, or cor	CXXX	July	0 / 1	328 Su	lph	ur S	oring	Rd.,	Arbu	tus, MD	212:	2.7
			shock, or heart failure. List ont	y one cause on ea	ch line.	o not ente	er the mode o	or crying	, such as	cardiac or	respiratory a	arrest,		Interv	ximate al Between and Death
	Physician /Medical		disease or condition resulting in death)		ZUN9		29Abl	SE							
	Examiner				rasa consequence		111071	VE	Dini	nan	IARY	Dis	FACT		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence	e of):	JUC 1 1	VE	. 101	LI V(U)	41/1/1	010	CHac		
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C											
Ö,	a exe ian al urial-t		resulting in death) Last	Due to (o	r as a consequence	e of):									
68760,	certificate ba executed nding physician and ise as the burial-transit	/Medicai	,	d											
9 xo	ertific ding p	/Me	IF FEMALE:	Ogo If was auto											
Bo	- 2	-	23b. Was decedent pregnant in the past 12 months?	1 Live bin	ome of pregnancy th 2 Fetal deal		Ectopic preg						23d. Date of del Month	very Day	Year
P.O.	w requires that the deatl been signed by the atte should be detached for	Physicia	1 □ Yes 2 □ No 9 □ Unknown	4 □ Pregna 9 □ Unknov	nt at time of death vn	5	Other (speci	†y)						,	, , ,
۳.	that ned by deta		Part II. Other significant conditions	contributing to dea	th but not resulting	in the un	derlying caus	se give	n in Part I.		23e. Did	tobacco u	use contribute to	the caus	e of death?
rds	quires n sigr	q p	HYPERTENSION	(CHRONIC	RF	NAL	FAI	LUR	RE.	10	Yes 2	□No 3□Pr	obably	4 ☑Unknown
00	s beer	iete	ATRIAL FIBRI	LLATIO	N						24a. Was	an	24b. Were au	tonsy figo	lings available
Re	The taw requires that the tee has been signed by the bage 2 should be detache	ompleted by	DIABETES A								auto	psy ormed?	death?	completion	of cause of
ital		e C	25. Was case referred to medical	100011					26 Place	of Death //	1 🗆 Yes Check only	2⊿No	1 Yes	2 🗆 No)
>	Physician: rthis certific ral director,	ToB	examiner? 1 ☐ Yes _2 ☐ No	Hospital:	patient 2 ER/C	utpatient	3 □ DOA	Othe					6 □Other (Spec	ify)	
0 U	ng Pt fter th neral		27. Manner of Death ∫ Natural 5 Pending	28a. Date of (Month)	Injury 28b.	Time of	28c.	Injury			d. Describe				
Sio	endin eath. or: A	catic	2 Accident investigation	on			М		es 2 🗆 i	No					
Division of Vital Records,	I or Attending after death. Director: After I in by the funer	Certification;	3 Suicide 6 Could not determined	1 286. Place 0	f Injury - At home, i g, etc. (Specify)	farm, stre	et, factory, o	ffice		281	f. Location (City or To	Street an wn, State	d Number or Ru)	ral Route	Number,
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		000 Continue 470 at 1							-					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier Certifying P (Check only one)	mysician: To the bas iminer: On the bas and manne	est of my knowledgis of examination a	ge, death nd/or inv	occurred at t estigation, in	he time my opi	e, date and inion, deat	d place, and th occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the car	JS8(S)
	vithin To the	Me	29b. Signature and title of certifier)			29c. L	icense	number			29d. Dat	e signed (Month	Day, Ye	ar)
)		7	De Eurl				PI	86	16			0.9	1271	05	-
ĺ	1 Ye		30. Name and address of person who	completed cause	of death (Item 23a)	(Type, F	Print)					- 0	-1001		
	V		DR. PRIYANKA NE	worl, G	100 CATO	NA	VENU	E,	ST. A	GNE	HE	FLAF	HCARE!	BAL	TIMURE
	Sta		31. Date filed (Month, Day, Year) MAR 0 2 2	32 A e	gistrar's Signature	Son	edel								
1,	Registr	ar	MAR 0 2 21	JUS JUS	LAN FO	1									
1.164	BAH 17 Day 1/00	101													

DELLAVECCHIA, JEAN.H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** 45 MICHAEL DuBOIS 4,2005 Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland n/a 8. Date of Birth (Month, Day, Year) Oct. 20,1956 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington D. C Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 ₺ M 2 🗆 F Yrs. 213-66-4772 48 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or Items 23s or 28a-f shov traumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 8302 Laico Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Ď Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 4 Owner Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Teresa Raymond DuBois Armalv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Dep. riment of Health ar
Important: If item 27 is
any injury or other trau 8302 Laico Court, Pasadena, Maryland 21122 Janice L DuBois (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cedar Hill Cem. Feb. 21,05 Brooklyn Park, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee Numm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 7 OUT APPROVED BY

CERTIFICATION APPROVED BY Immediate Cause (Final COMPLICATION **Physician** FROM SUBBURAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STARE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed org Anc that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HY?OTHTROIDISM 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 2/ No 1 Yes Division of Vital 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1∑ Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred becedent fell down stairs at Certification; 1 Natural 5 Pending 1 ☐ Yes 2 🕱 No investigation 1-28-2005 hours after death. 2 Accident
3 Suicide
4 Homicide unknour residence Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in by t determined \$30 2 Laco C+ at home within 24 hours a Lake snove, MD 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d, Date signed (Month, Day, Year) 29b. Signature and title of fertifier 29c. License number S S D0059648 END(NS

State Registrar

DHMH 17 Rev 1/2001

522

DOLPHIN STREET

BATIMORE

41512 CM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

A CONTRACT

2005

31. Date filed (Month, Day, Year)

MAR 02

		For State Registrar	State of Marylan		rtment of			piene 005	06761
Physi	cian	1. Decedent's Name (First, Middle, Last) RICHARD	GUIDO	DAMARI	0		2. Date of Dea FEBRUAR		3. Time of Death
/Med Exam	dical niner	4a. Facility Name (If not institution, give s GENESIS HAMMONDS			-	, or Location of De		4c. County of Dear	th
Funera Directo		5. Social Security Number 6. Sex	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Ye Months Day	ar If Under 24 H	Irs. 8. Date of Birth (Month, Day Dec 30	y Year) 9. Birt	hplace (State or Foreign puntry) aryland
yland now		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
he Mar 28a-1 st	Director	Maryland Anne Arun	del	Balti		_			1 Yes 2 No
h with 1	al Dir	817 Sunnyfield	Lane		10f. Zip Code	225		10g. Citizen of What Co USA	ountry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. Tof Health and Mental Hygiene. Tof Health and Mental Hygiene. To the resumetic event, the Medical Examinar must be notified at or other treumetic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1√Yes 2 □ No If Yes, Give Year or Dates: Kore		Vas Decedent of Yes, specify C		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
vithlo 72 hone. hen "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) Coilege (1-4or 5+)	(Give i life. C		ne during most of v ired)		16b. Kind of Business	·
filed w Hygier other th	a	17. Father's Name (First, Middle, Last)	5+	Dir	ector	of Final	NCE	Allied-Si Maiden Sumame)	gnal
Mal yialla Z IZ I. 12 should be filed within h and Mental Hygiene. 7 is marked other than " iraumatic event, ins Mes	To B	Guido Damar	io				tta Citrar		
od 2 shouth and 27 is muttraum		19a. Informant's Name/Relationship (Type Cecelia H. Damario	_{e, Print)} (Wife)				Rural Route Number Baltimore	r, City or Town, State, 2	
parmit. Pages 1 and 2 Department of Health a Important: If itam 27 is any Injury or other tre	-	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other p			e, Md. 212 20c. Location - City or	
it. Pages rtment of rtant: If it		1 X Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)		lar Hil	1 Cemet	ery 2/	26/2005	Baltimore,	Maryland
Derm Depa Impo	9000 9000	21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complice shock, or hear failure. List only on	ations that caused the death					Home, P.A. to., Md. 21 est	225-1856 Approximate Interval Between Onset and Death
Physicia /Medica Examine	al	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)			NEum	MENTIT	4	
cate be executed obly sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a conse	uence of):	UER'S	1) +>	11/12/1/11		
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OI VICAL Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \times No	ospital:	ER/Outpatient	t 3 DOA		Death (Check only on Home 5 \to Reside	ence 6 □Other (Spec	cifu)
UNISIOII OI VIIGI ING To the Hospital or Attending Physician: The la wilnin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; T	27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. ir			ow injury occurred	,
tal or Att rs after de al Diract	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, offic	CB .	28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation, in m	y opinion, death oc	ccurred at the time, d	ate and place, and due	to the cause(s)
To To C	2	29b. Signature and title of certifier	~	M	29c. Lice	5 / 59 (9d. Date signed (Monti	
104	2/	30. Name and address of person who cou	npleted cause of death (Item	1 23a) (Type, I	Print)			February	
	State	K. Ambala Vavar. 31. Date filed (Month, Day, Year)	7845 Octo	turge	Koav,	103 G	Ilen Burn	CR. MD	21061
Regi		MAR 0 2 2005	32. Registrar's Signa	3034	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Day 26, 2005 **Physician** PATRICIA DeVOTER JANEEN 6:00 р м /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore n/a Joseph Richey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. March 23,1954 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 M F Maryland Director 216-66-4982 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3200 Ryerson Circle 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Deli Supervisor Giant Food permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked othar than any injury or other traumatic avent timore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry J. McGuirk Phyllis Phyllis Μ. Welsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 149 Myrtle Ave Severn, Maryland 21144 Mark A. DeVoter (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem Park 03-03-05 * 4 □ Donation 5 □ Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryand 21225 alin Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** KESPIRATORY WEEKS /Medical + LUNG CANCER Examiner dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CORONALY HEART DISEASE 1 Yes 2 No 3 Probably 4 Unknown DIABLETES MERCITOS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an HYPERTENSION 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes luneral 27. Manner of Death 28a. Date of Injury (Month, y Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number - 1425 BOLTON ST BACTIMORE (10) 21217 (, Holdwitz, MD , Year) 32. Régistrar Signature MARCEL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 02

2005

	1	t.	For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of F tificate of	lealth and M <i>Death</i>		iene () ()	5 06763
	Physici	an	1. Decedent's Name (First, Middle, Last)	Y E.				2. Date of Dear	th Day Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number) OSFITAL CE	NTER		r Location of Death	FEBRUAI V	4c. County of I	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	(ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	17	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	83	Yrs.			01/23/		ORTH CAROLIN
	show	ž	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N 28e-f	rect	MD N/A 10e. Street and Number		BALTI	MORE CI	TY	1	0g. Citizen of Wha	A
	th with	ai Di	5006 HAMPSHIRE	AVENUE		2120	7		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show may injury or other traumatic event. The Medical Examinatic usit for notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married	2. Was Decedent Ever in U. Armed Forces? XXYes 2 □ NoUS If Yes, Give 1.942 – Year or Dates.	ARMY	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. BLACK
5-0036	72 hou	ted	15. Decedent's Educa (Specify only highest grade	ation	16a. Deced	lent's Usual Occup	pation		16b. Kind of Busin	
2121	should be filed within 7 nd Mental Hygiene. marked other than "r imatic event, the Med	Completed	Elementary/Secondary (0-12) 8TH	College (1-4or 5+)	life. L	EL WORK	,	ng	BETHLEH CORPORA	IEM STEEL ATION
	be filed htal Hygie od other event.	Be	17. Father's Name (First, Middle, Last) JOE DAYE				18. Mother's Name			CE NAME)
Maryland	should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailin	g Address (Street	BLANCHE and Number or Rura			AST NAME)
	and 2 sho salth and n 27 is m			FE	1					, MD 21207
Baltimore,	Pages 1 and 2 nent of Health out: If item 27 I iry or other tru		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Re	moval from State	Place of Disportence	sition (Name of natory or other place	03/0		20c. Location - Cit	
<u>=</u>	permit. Page Department of Importent: If any injury of once.		* 4 □Donation 5 □Other (Specify) 21. Signature • Uneral Service Licensee	MAR	YLAND RISON	VETERA	NS CEM.		OWINGS	MILLS, MD
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			23a. Part . Enter the disease, or complice shock, or hear failure. List only one	ations that caused the dual	h. Do not ente	er the mode of dyir	ng, such as cardiac o	r respiratory arr	est,	Approximate Interval Between
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<u>α</u>	s that the gned by th se detache	by Ph	Part II. Other significant conditions conti	ributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribu	te to the cause of death?
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	Hospite 4 hours Funeral ely fillec	edical C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death ition and/or inv	occurred at the tir restigation, in my o	пе, date and place, a pinion, death occurre	and due to the ca	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
	To the l within 2. To the l complet	Me	29b. Signature and the of certifier	PHYSICI	AN	29c. Licens	e number 4272		9d. Date signed (N EBRUARY	Honth, Day, Year)
/	210		30. Name and address of person who com	pleted cause of death (Item	n 23a) (Type,	Print) NO	RTHWEST	HOSP	ITAL	CENTER.
			AVVERARALI 31. Date filed (Month, Day, Year)	Registrar's Signa	HORIS	H 5401	OLD Co.	SOUT R	CA0	ww 31133
	Sta Regist	ate rar	MAR 0 2 2005	Charles Signa	Spa	de				

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Sofia Rose Davila Day Month YARI **Physician** February 24, 21, 4c. County of Death 7;30 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Greater Baltimore Medical Center Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Days Months Hours Min. None Yrs. MD Director 24 2005 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 €No Funeral Director CockeySVIlle 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 12 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturai", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Infant other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Davila hael ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/030 le 2/129 Baltimore, Date 20b. Place of Disposition /Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 or other place. 1 ☐ Burial 2 🛣 Cremation 3 Removal from State in ury or CUNT CAMPTONY 5 Other (Specify) 4 □ Donation permit. 21. Signature of Furjeral Service Licensee 22. Name and Address of Facility 6 16924 YORK alle MUNC S JONKTON IN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year ŏ 4 Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown 02 24 2005 9 Unknown been signed by I should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has I irector, page 2 s autopsy performed? 2 No 1 ☐ Yes Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation Injury Division 1. Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by determined 4 Homicide ō To the Hospitel to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) All Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Ligense number 29d. Date signed (Month, Day, Year) 29b. Signature and titletof certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 710 Marwan Suite ·Charles Ha Towson Registrar's Signature 31. Date filed (Month, Day, Wear) State

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			For State Registrar	0	State of	f Marylar	nd / Depa		t of H	ealth a		lental Hygi	ene	DIG.	000	
			Hegistrar Decedent's Name (Fi	irst, Middle, La	st)			uncate	OIL	Jean -		2. Date of Death	g. Na <u>. </u>	UJ	3. Time of	Death
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	/Medio Examin		4a. Facility Name (If not	institution, giv			, dilli	4b. City,	Town, or	Location o	of Death	repruar	-	y of Death	3:30	a "
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	Funeral		5. Social Security Numb			7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birth		,	place (State o	r Foreign
П	Director		577-26-31	./3	1 □ M 2 X F	82	Yrs.	Wichitis	Days	110013	Willi.	Feb. 22	1923	Mar	ÿland	
	and *		Usual Residence of Dec 10a. State 10l	b. County		10c. Ci	ty. Town or Lo	cation						-	0d. Inside Cit	by Limite
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	the A	rect	10e. Street and Number					10f. Zip	Code			10	g. Citizen of	What Cour		
	3a or		7704 Hand	over Pa	rkway.	#301			2077	'n			g. ezo.r o.	USA	y .	
	death ms 2;	by Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.1	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ice - Americ	an Indian,	
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93	ours .	db	3XXWidowed 4 □	Divorced	If Yes, Gi Year or E	ve lates:		1 ☐ Yes 2	ALANO	Specify:			Spec	ity:	White	
21215-0036	within 72 hours after death with the Maryland ene. than "naturaf", or itams 23e or 28e-f show fre Madical Exeminer must be notified at	Completed	15. (Specify o	Decedent's E	ducation ade completed)		16a. Deced	kind of wor	k done d	urina most	of worki	ng 1	6b. Kind of I	Business/In	dustry	
12	within ane. than	mp	Elementary/Secondar	ry (0-12)	College (1-4or 5+)		naker	e retired)				Own	Uama		
2	filled Hygin ther	ပိ	17. Father's Name (Firs	t, Middle, Last)		Home	maker		18. Mothe	r's Name	(First, Middle, M			·	
Maryland	id be ental ked c	To Be	Joseph C.	Rabbi	tt					В	erth	a Smith				
ary	shou and M a mar umat	-	19a. Informant's Name/				19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	il Route Number,	City or Town	n, State, Zip	Code)	,
	and 2		Carolyn D	. Poin	dexter	(Daught	er) 33	8 Tho	rsby	Hi11	, Sh	nerwood 1	orest	, MD	21405	
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposit 1 ☐ Burial 2 ☐ Cr		Damoval from	20b. F	Place of Dispo	sition (Nam	e of her place)	C	ate 2	0c. Location	- City or To	wn, State	
Ē	Pag ment ant: f ury o		`4 □ Donation 5 □				etro C	remat	ory	2	/28/	′2005 I	Baltim	ore, l	MD	
Baltimore,	permit Depart Import any inj pnce.		21. Signature of Funera	Service Jice	nsee		22	Name and				Home, P.	Α.			
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	Prysician /Medical		Immediate Cause (Fina disease or condition resulting in death)	11	_ a	1	epa	10	un	4					_	205
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8760,	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	cal			d											
9	artifica ing ph e as th	Physician/Med	IF FEMALE:													
Вох	ath ce	ian/	23b. Was decedent pre in the past 12 mor	gnant Mhs?	1□Live I	tcome of pregna pirth 2 Peta	al death 3	Ectopic pre						ate of delive	-	ear
P.0.	res that the death certific igned by the attending p be detached for use as	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown)	4∐Pregi 9⊡Unkn	nant at time of c own	leath 5∟	Other (spe	ecify)						, .	
٥.	that the	Ph	Part II. Other significan	nt conditions	contributing to d	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did toba	acco use cor	tribute to th	e cause of de	eath?
Division of Vital Records,	uires sign ld be	d by			1916				_			1 ☐ Yes	2 10 NO	3 ☐ Prob	ably 4 □U	nknown
CO	w require been si should b	lete			3							24a. Was an	24h	Were auto	osy findings a	vailable
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\leq	or Atl fter d jirect in by	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	determined	28e Place	e of Injury - At hing, etc. (Specif	ome, farm, str fy)	eet, factory,	office		2	28f. Location (Stre City or Town,		ber or Rura	l Route Numb	oer,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2]	Medicel ⊱xer	miner: On the h	asis of examina	ition and/or inv	/ectination	ID MY OD	inion dest	h occurre	and due to the car ed at the time, da	e and place	and due to	ated. the cause(s)	
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1	011		30. Name and address	of person who	completed caus	se of death (Iter	п 23а) (Туре,	Print)	-	,			2 \			
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State of Maryland / Department of Health and Mental Hygien 0 0 5 06766 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 611PM Drace 200 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kidg R 5. Social Security Number If Under 24 Hrs. Ca 1101 8. Date of Birth (Month, Day, March 3 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 M 2 F 081-12-0170 Director Yrs. 1918 NY March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MA Barnstable Yarmouth Port Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23e 61 Congressional Drive 02675 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry perriit. Pages 1 and 2 should be filed within 7;
Department of Health and Mentat Hygiene.
Important: If Item 27 Is marked other than "na any injury or other fraumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grover F. Muller May C. Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Daly (son) 5804 Greenspring Ave., Baltimore, Md 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 ▼ Removal from State
4 □ Donation 5 □ Other (Specify) Nassau Knolls Cemetery 2-25-05 Port Washington, NY 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Things Haigh P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Crebiovas /Medical Due to (or s a consequence of): Examiner neumon Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?) enertra 1 ☐ Yes 2 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🙀 🛱 o 2 1 🔲 Inpatient 2 ER/Outpatient 3□ DQA After this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MO 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Stone 31. Date filed (Month, Day, 32. Registrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Donawa 2005 10:20 tebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dundalk If Under 1 Year Marshall AVE Baltimore If Under 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 10 M 20 F Months Days Hours Min Yrs. 216-69-8508 Director Trinadad Usual Residence of Decedent should be fited within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Dundalk MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: West Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Indian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Nelder Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Evans Hugh Donawa Rasulan 19a. Informant's Nam Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nt of Health a t: If item 27 is y or other trae 6432 Woodlawn, *D.* Lennert Zalima Johnson - gaughter 21207 mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation /5 □ Other (Specify) 1-05 Catonsville, mo Crematory metro 23a Hart. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limmediate dause (Final disease or condition a. LUN G. A.I.A.— O GORY P. MGACH FIH 240 FREDHILTON PASS BALTO. MD 21229 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No 24a. Was an page 2 s autopsy performed 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hin 24 hours after the Funeral Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registr's Signature

2005

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year George Economides 10:15 a^M February 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Min. About 1 Year If Under 24 Hrs. Min. Min. Jan. 7, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10XM 201F 022-20-6561 Director 95 YES Turkey Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinat must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2 Ritchie Road 21401 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Clergy Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Urania Michalides George Economides 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Economides (Wife) 2 Ritchie Road, Annapolis MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) St. Demetrios Cem. 2-18-2005 Annapolis, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SF-L CI B disease or condition resulting in death) /Medical Due to (or as a consequence) Examiner Sequentially list conditions, any, sading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): ettending physician Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 3 Probably 4 Unknown 1 Yes 2 Wo Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) a Hospital or Attending Pl 24 hours after death. 9 Funeral Director: After the 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 02 2005

					rtment of Health and M tificate of Death		ene 005	06769
		Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yea	3. Time of Death
		/Medi	cal.	Norma L. Edwards		February	24, 200	5 8:05 AM ^M
10		Examir	ner	4a. Facility Name (If not institution, give street and number) Oakcrest Village	4b. City, Town, or Location of Death		4c. County of D	
50.		. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth		timore
00		Director		482-09-6888 ^{1 □ M 2} ▼F 89 Yrs.	Months Days Hours Min.	(Month, Day,) Mar 24,	(ear) 1915 Ne	Birthplace (State or Foreign Country) braska
		pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Loc				
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2		the N 28a-f	ect	MD Baltimore Baltimo:	10f. Zip Code	100	- Chi 11/h - 1	
20		death with the Maryland ms 23a or 28a-f show must be notified at	0	8820 Walther Blvd #204	21234	109	g. Citizen of What USA	Country ?
30/hz/c		death	Funeral Director		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	merican Indian,
,Q	9	or Ite	y Fu	1 Never Married 2 Married 1 Tes 2 MNo	Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 1 No Specify:	Hican, etc.)	Black, W	
5	Ş	hours turel',	d by				Specify: To	
3	15	in 72 n "ne	Completed	(Specify only highest grade completed) (Give killife Di	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ng 16	6b. Kind of Busine:	ss/Industry
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DNARDS	pu	al Hy d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		iden Sumame)	
2	yla	ould I Meni narke	ပ	Raymond Lambert		Kretchman		
9	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Marical Examiner must be notified at Once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ralph Edwards/spouse 8820	Address (Street and Number or Rura Walther Blvd #20	<i>l Route Number, (</i>)4 Raltim	City or Town, State	, Zip Code) 21234
B		tem 2		20a. Method of Disposition 20b. Place of Disposi	ition (Name of		c. Location - City	
SMA	ê E	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☒ Donation 5 ☐ Other (Specify)	atory`or other place)			
0	Baltimore,	permit. Departmimporte any inju			Name and Address of Facility Late Anatomy Board	1 655 W	Roltimor	o Ctroot
4	<u>m</u>	89 1 2 9		Ba	altimore, MD 2120	01		e Street
	г			23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter shook, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)				Onset and Death
		/Medical Examiner		Due to (or as a consequence of):				
			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		<u></u>		
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	Box	atten after d for u	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3 E	ctopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
	P.0.	t the d by the achec	hysi	9 ☐ Unknown 9 ☐ Unknown	Suite (Speeny)		_	
	S,	w requires that been signed b should be det	ру Р	Part II. Other significant conditions contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobac	co use contribute	to the cause of death?
	ord	equire sen si ould b	ted	CHT, lymphoma		1 🗆 Yes	2 □ No 3 □ I	Probably 4 Unknown
	ec	has by	Completed			24a. Was an autopsy	prior to	autopsy findings available completion of cause of
	al H	Physician: The la r this certificate has ral director, page 2				performe 1 Yes 2	death?	· _
	Vit	sician	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
	of	Phys r this sral di	. To	1 Yes 2 No Pospiral 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Northern Street	3 DOA 4 Amursing Hom	ne 5 Residence 8d. Describe how		ecify)
	ion	nding ath. r: Afte e fune	atior	1	28c. Injury at Work? M 1 Yes 2 No		,,	
	Division of Vital Records,	r Atte er dez recto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 2	8f. Location (Stree City or Town, S	at and Number or F	Rural Route Number,
		itel o rel Di rel Di						
		Hosp 24 hou Fune etely fi	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death of 2 Medicel Exeminer: On the basis of examination and/or investant and manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	as stated. se to the cause(s)
_		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mor	nth, Day, Year)
		`.		12	053115	Fe	Jury 21	1 2005
				30. Name and address of person who completed cause of death (item 23a) (Type, Pr	1 1 1 1			
				Jeff Con / no odco Wollw 31. Date filed (Month, Day, Year) 32. Redistrar's Signature	DI-J Parkulle	MO.	21234	
	4	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2005 32. Registrar's Signature	rade			

			1- For State of Maryland / Dep	artment of Health and M		ene 2005	06770
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Gladys L. Faust		2. Date of Death Feb. 27,		3. Time of Death 2:10pm
	Examir		4a. Facility Name (If not institution, give street and number) 1225 Cedarcliff Drive	4b. City, Town, or Location of Death Glen Burnie, MI		4c. County of Death Anne Arun	de1
	Funeral Director		$\begin{array}{cccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 8	9. Birth Coul 1917	place (State or Foreign ntry) MD
	Marylanc B-f show	tor	MD 10b. County 10c. City, Town or L	ocation Glen Burnie		1	10d. Inside City Limits 1 ☐ Yes 2☐No
	th with the 23a or 28	ai Director	10e. Street and Number 1225 Cedarcliff Drive	10f. Zip Code 21060		Citizen of What Cour United Stat	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or itams 23e or 28e-f show eny injury or other treumatic event, the Wedical Examination at a notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ Xo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	Ithin 72 hou ie. ian "neture ika irel E	Completed	15. Decedent's Education (Specify only highest grade completed) [Give Flementary(Secondary (0.12) College (1.4or.5.) life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/In	dustry
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Maryla	d 2 should th and Men 7 is marke treumatic	D_	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Run North Academy St.			
Baltimore,	Pages 1 and 2 nent of Health ont: If item 27 i		20a, Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	Date 20	C. Location - City or To	own, State
Balti	permit. I Departm Importer eny inju		21. Signature of Funeral Service Licensee Victor P. Doda, Jr.	2. Name and Address of Facility harles L. Stevens Fune 1501 Fast Fort Avenue,	ral Home. 1	īrc.	
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20,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	I Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
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Division of	ding After fune	Certification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined determined	Work? M 1 □ Yes 2 □ No	28d. Describe how 28f. Location (Stree	injury occurred et and Number or Rura	l Route Number
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	To the Ho within 24 I To the Fu completel	Medical	(Check only 2) Medical Examiner: On the basis of examination and/or in	vestigation in my opinion death occurr	ed at the time, date	and place and due to	the cause(s)
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)		30. Name and address of person who completed cause of death (Item 23a) (Type, Au C. Deinny M. 90 / 6	y Fof Au. B	a/ Lonare	, Mis 2	-1230
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2005	. Books			

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death				For State		nd / Department of	Health and Mo	ental Hygien	9005 0	6771
Social Security Number Social Security Num		/Medic	al	1. Decedent's Name (First, Middle, Last HELEN 4a. Facility Name (If not institution, give	RENE F	-LEMING 4b. City, Toyon	, or Location of Death	2. Date of Death Month DEBRUAR	y 25 2005	Time of Death
Black, White, at C. The C. Mark S. Specify The Community		Director		5. Social Security Number 6. Se 220 · 24 · 2998	x 7. Age (In yrs.	last birthday) If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace MARY	(State or Foreign
Black, White, at C. The C. Mark S. Specify The Community	he Maryland	Ba-f show	ector	MD	10c. Cit	BALTI MORE			1	nside City Limits
Black, White, at C. The C. Mark S. Specify The Community	death with t	ns 23a or 2 Inust ke n	eral Dir	3500 EDNOR	RIAD Art 12. Was Decedent Eyer in U	#128	2/2/8		U.S.A.	ndian.
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19 10 10 10 10 10 10 10	21215-(d within 72 t	jiene. ir than "nati ir a Medicu	ompiete	(Specify only highest grad	ie completed)	(Give kind of work dor life. DO NOT use reti	ne during most of workin ired)	g		,
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1	- 5	Health and sm 27 Is n ther traum		WILLE A. FLEMIN	16 HUSBAND	3500 EDNI	OR KOAO	BALTIM	ORE, MO 2	1218
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Control on Section (Interval Betwe	timor Pages	○ = 1		1 Burial 2 □ Cremation 3 □ I '4 □ Donation 5 □ Other (Specify,	Removal from State GA	cemetery, crematory or other p	lace)		•	
Physician // Medical Examiner Physician // Physician // Medical Examiner Physician // Physician // Physician // Physician	Bal	Depar Impor any in		21. Signature of Funeral Service Licens	Green	22. Name and Add 4905 %	RK RIAD	BACTIMO	RE, MARYLA	NATE HOME
Second S	760, ie be executed u	Medical and points is partial transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence) Due to (or as a consequence)	uence of): IVE 1-+EX uence of):	ART F	AILUR	Ons 12	
24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 3 Probably 4 Unknown of the completion of cause death? 1 Yes 2 No 4 No	Box death cert	/ the attending ph ched for use as th	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3 □ Ectopic pregnar				Year
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Time of Injury 28. Date of Injury 29. City or Town, State) 29. Certifier (Check only 29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	rds, P.	n signed by	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cause o	given in Part I.			
1 Yes 2 to No 1 Inpatient 2 ER/Outpatient 3 DOA Outside 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Descri	:al Recol			OF Manager referred to medical				autopsy performed?	prior to completed	ion of cause of
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only (Ch	C g	leath. tor: After the fune	rtification	1 Accident 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) 28e. Place of Injury - At ho	Injury W M 1	/ork?	Bf. Location (Street a	and Number or Rural Rou	ite Number,
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	To th	within To the compl	Me	29b. Signature and title of certifier	Mari	11.				
30. Name and address of person who completed duse of death (Item 23a) (Type, Print) MD AT 2438946 2-25-200	10	10/		30. Name and address of person who c	ompleted duse of death (Iten		243894	6 2	くー スラーる	1005
State Registrar State Registrar	10			31 Date filed (Month Day Year)	32 Raffistrar's Signa	ature	2 201 EAST	INIE KSI	TY PARKWAY	BALTEMARA

		1 - For State Registrar	State of Marylan		nent of Health cate of Deat	h	I Hygiene Reg. No	2005 06	772
/Me	ician	Decedent's Name (First, Middle, Last ALVERTA ID. 4a. Facility Name (If not institution, give	A FORBES	4b	City, Town, or Location	FE FE	B. 23	Year 2005 7:30	
Funer Direct		FUTURECARE – (5. Social Security Number 6. Se 220–18–9950	OLD COURT	last birthday) If	RANDALLST	OWN	_	ALTIMORE	
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. Cit	y, Town or Location	rimore ci	TY		10d. Inside Ci	•
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Daltimo permit. Page Depertment (Important: If any Injury or	- 500G	1 M Burial 2 Cremation 3 1 14 Donation 5 Other (Specify 21. Signature of Turberal Service Licens 23a. 41 For the digns, or composit,	icate is that used the define cause on each line.	22. Na 460	me and Address of Fac 0 0 LIBERT e mode of dying, such a	Cility HOWEL: Y HGHT'S as cardiac or respir	L FUNE AVE.,	TIMORE, MD RAL HOME 212 BALTIMORE, Approximate Interval Behoved and Conset	MD e ween
Examination and pairs it is principle.	a a le licai Examiner	dise or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of): 2 be to cuence of): Hupe uence of):	melli- melli- ercholes perten	tus -	Type II		
dS, P.O. BOX 08/ ires that the death certificate signed by the attending phys d be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 □Ecto	opic pregnancy ner (specify)			? 23d. Date of delivery Month Day ?	Year
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_ @ _	Comp	25. Was case referred to medical			26 Pla		a. Was an autopsy performed? Yes 2 No	24b. Were autopsy findings a prior to completion of cadeath? 1 ☐ Yes 2 ※ No	available ause of
	O B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other			6 ☐Other (Specify)	
DIVISION OT To the Hospital or Attending Phys- Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2	28d. De	scribe how inju	y occurred	
DIVISION Att	Certifi	4 Homicide determined	building, etc. (Specif	(y)		City	y or Town, State		ber,
the Hosp in 24 ho tha Funa	ledical		sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occ tion and/or investi	gation, in my opinion, d	eath occurred at th	e time, date and	I place, and due to the cause(s)
2 1 2 2 2	13	29b. Signature and title of certifier			29c. License numbe		1	te signed (Month, Day, Year)	
jur		30. Name and address of person who co			*	HETTE	Ave	Belty mo	21210
Pos	State	31. Date filed (Month, Day, Year) MAR 0 2 26	32. Begistrar's Signa		N. 3	,			

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	Physici /Medic Examir	cal	Decedent's Nam Carolyn D. 4a. Facility Name ((Smith)		ımber)		4b. City,	Town, or	Location	of Death	2. Date of De Month February	7 28	y Ye 200		3. Time of De	
	Funeral		4120 Fair	Number	6. Sex 1 ☐ M 21 X F	7. Age (In y	rs. last birthday) 56 Yrs.		Ltimo			8. Date of Bir (Month, Da	th ly, Year)	9.	NA Birthpla Countr		reign
	Director		218–48–1850 Usual Residence of 10a. State			10c.	City, Town or Lo	ocation				02-08-19	949	Ma	ryla:	nd d. Inside City Li	imits
	th the Man or 28a-f sh a notified	irector	MD 10e. Street and Nu	mber	NA .		Bal	timore 10f. Zip	Code				10g. Cit	izen of Wha	t Counti	1 🗓 Yes 2 🗆] No
936	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinar rrust be notified at	by Funeral Director	4120 Fair 11. Marital Status 1 Never Marital 3 X Widowed	ried 2 Mar	ried 1 ☐ Yes	ve				spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	-	USA 14. Race - A Black, V	Vhite, et		
Maryland 21215-0036	within ene. than "	Completed	(Spec Elementary/Seco 12	cify only highe	t's Education st grade completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Loan (rk done a se retired,	luring mos)	t of worki	ng	16b. K	ind of Busine		stry	
yland	should be filed ind Mental Hygi marked other umatic event, II	To Be C	17. Father's Name Charles C.	Smith							Ada 1	(First, Middle, B. Smith					
	1 and 2 s Health ar tem 27 ls other trau			ith/ Mot position □ Cremation	ner 3 □Removal from	State		airfax sition (Nam matory or or	Road	Balti	more,	MD 21216	20c. Lo	ocation - City	or Tow	n, State	
Baltimore,	permit. Pages Department of Important: If it any injury or once.		' 4 □Donation 21. Signature of Fi				22	. Name an	d Addres	s of Facilit	у			altimore et Balt	•	e, MD 212	17
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). Box 68760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2[t pregnant months?	d	ointh 2.∏Fe nantattime of	mancy	Ectopic pre						23d. Date of Month		ay Year	
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al Records,		Completed								_		24a. Was a autop perfor	sy	24b. Were prior death	to comp ?	y findings availa letion of cause	able of
ion of Vital	Attending Physician: 7 death. 8ctor: After this certifica 9ctor: After this certifica	atlon: To Be	25. Was case referexaminer? 1 Yes 2 27. Manner of Deat 1 Natural 2 Accident	No	Hospital: 1 28a. Date (Mon		ER/Outpatien 28b. Time of Injury		Sc. Injury Work	r: 4□ Nur at	sing Hom	(Check only or the 5 Thesid 8d. Describe h	ence 6	Other (S	pecify)		
Division	in the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could I	ined 286, Place	of Injury - At ng, etc. <i>(Spe</i> c	home, farm, stre	eet, factory,	office		2	8f. Location (S City or Tow	treet and n, State,	d Number or	Rural R	oute Number,	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)	2 Medical		best of my ki asis of examin ner stated.	nowledge, death nation and/or inv	estigation,	in my opi	inion, deatl	l place, a	d at the time, d	late and	place, and d	lue to th	e cause(s)	
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	Sta	te.	30. Name and addr	W. E	who completed caused by the completed by the completed by the completed by the completed by the completed by the completed by the completed by the completed by the completed by the complete	e of death (Ite	Ave	Inti)	Sali	6.	M.	D 2	42	15			
	Registr	_	3-2	05	MAR 02	2005	Magne	, Jr.	A	mark							

State of Maryland / Department of Health and Mental Hygiene U 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Garnetta Gibson 01:44AM March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-28-1923 5. Social Security Number 217-18-3822 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 82 Days Hours Min 1 □ M 2 1 F Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at MD Baltimore Halethorpe 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 Summit Ave 21227 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
anti If Item 27 is marked other then "naturel; or Ite any or other treumatic event, the Medical Examiner by or other treumatic event, the Medical Examine. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite 3√√Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Ownhome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Beck P Marie Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Bogdan/Daughter 106 Glenrae Drive Catonsville ND 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Importent: If It eny injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 03/04/2005 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) 21. Si in riure di Juneral Service Libense Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus MD 21227 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Myocardial disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine sician and burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed tortic stenosis resulting in death) Last Due to (or as a consequence of): nding physician use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached t 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform death? 2XNo 1 Yes 2X No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a

To the Funerel I

completely filled lilled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435V-16020 March 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Play Baltimore MD enanzi, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 02

Registrar

ENELLE.

Reginald D. Gray Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-1400 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 23, **Physician** 2005 Reginald Gray 5:42 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner Johns Hopkins Hospital NI Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 10 MM 2□ F MD 212-13-0142 Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner roust be notified at Baltimore MD Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 21206 Kavon Jolel items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 21 No Black Specify: Specify: Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College, (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other trainmast. Electrician ontractor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Keainald Gray, Sr. 19a. Info ant's Name/Relationship (Tyo 19b. Mailing Address (Street and Number or Rural Plbute Number, City or Town, State, Zip Code) Mother Baltimore MD 21206 Mirteu Kavon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 03:01:05 PACTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, Name and Address of Pacifity
OUNDER CONTENT FUNERAL SERVICES Vau YORK ROAD BACTIMORE MD 2/212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GUNSHOT WOUND TO THE BACK OF THE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 🗆 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 2 1 X Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospitel or Attending P 24 hours after death. Funeral Director: After to Certification: Division 1 Natural 5 Pending SUBJECT WAS SMOT 4:598 1 ☐ Yes 2 X No investigation 2 Accident 123/05 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide STREET 2801 ST LO DE Bathwair, MD within 24 hours at To the Funeral D completely filled i INCIDE CAR 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 OCME February 24, 2005 auge 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 RUBIO, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 02 Registrar 2005 Magnas & Speciel

Division To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical Certification
State Registra	te

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		•	For State Registrar		Otate of Wi	•	rtificate of			Reg. No. 2	005	06776
		40		e (First, Middle, La	st)				2. Date of De	aath	Voor	3. Time of Death
	Physicia /Medic		Myra	Lee Gard	dner				FEBRUAR	-y 25	Year 2009	: (2:24 PM
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	/land		10a. State	10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
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	th the	Director	10e. Street and Nu	ımber			10f. Zip Code			10g. Citizen of	What Co	untry?
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	er de Items	Funeral	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐		If Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		ack, White	rican Indian, e, etc.
35	irs aft	by F	3 X Widowed	-	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Spec	ify: W	hite
315-UU36	filed within 72 hours after death with the Maryland Hygione. Hygione insturat', or Items 23a or 28a-f show that the Macical Examination out to millified at ant, it e Macical Examination.		/C=0	15. Decedent's E	ducation	16a. Dece	edent's Usual Occu	pation during most of work	rina	16b. Kind of	Business/I	ndustry
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Maryland	ດ ≥ ຂ ຄ	ို		Name/Relationship (19b. Mai	ling Address (Stree	at and Number or Rui			n, State, Z	ip Code)
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of F	funeral Service Lice	Hist	Н́	AIGHI FUN	VERAL HOME NERAL HOME NE MD 2178	& CHAP	PEL, PA	(Box	195)
ĸ.			23a. Part1. Enter	the disease, or com	plications that caused	d the death. Do not en	nter the mode of dy	ring, such as cardiac	or respiratory a	1-793-12 arrest,	100	Approximate Interval Between
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760,	Attanding Physician: The law requires that the death certificate be executed rideath. actor: After this certificate has been signed by the attending physician and actor: After this certificate bas been signed by the tuneral director, page 2 should be detached for use as the burial-transit	_			d							
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Вох	death certificate b attending physic for use as the b	Physician/Medica	IF FEMALE: 23b. Was decede		23c. If yes, outcome		□Ectopic pregnan	cy			ate of deli Month	very Day Year
B	e deal he att	sicis	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	₽No	4☐Pregnant a 9☐Unknown		Other (specify)			10	nontri	Day Tear
Р. О.	that the de led by the a detached t	Phy			contributing to death I	out not resulting in the	underlying cause o	Iven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
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ta	ysician: The is certificate hadirector, page	a	25. Was case refe	erred to medical				26. Place of Dea	1 ☐ Yes th (Check only	one)	1 1 1 1 1 1 1 1 1 1	25 110
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Sio	tandi eath. tor: A the fu	catl	2 Accident	investigation 6 ☐ Could not I				∃Yes 2□No	20f Location	/Ctroat and Mus	nhor or O	ıral Route Number,
Division of Vital Records,	i i i te	Certification:	4 Homicide	dotormino	200. Flace Of III	ijury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office	Ð	City or To	own, State)	nper or no	rai noute Number,
	a Hospital 24 hours a e Funaral l letely filled		29a. Certifier	1 ☐ Certifying P	hysician: To the best	of my knowledge, dea	ath occurred at the	time, date and place	, and due to the	cause(s) and r	nanner as	stated.
	To tha Hospital or Attanding Phwithin 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical	(Check only one)	2 ☐ Medical Exa	miner: On the basis of and manner s	of examination and/or tated.	investigation, in my	opinion, death occu	rred at the time	, date and place	and due	to the cause(s)
	To tha within 2 To the complet	Me	29b. Signature ar		14.		29c. Licer	nse number		29d. Date sign	ned (Month	h, Day, Year)
)	1 11		> Per	in W.C	lo, IND.	surgeon	Ď	41129		FEBRUA	nry z	5,7005
6	211			dress of person who	completed cause of M.D. S	death (Item 23a) (Type inch Hospil	e, Print)	Minune	Bachim	me, MI) 2	21215
	Sta Regist	ate rar	31. Date filed (Mo	MAR 02	32. Regist	Surgeon death (Item 23a) (Type inch Hospit trar's Signature	Sparke					

IE GADD		1 - For State Registrar	State of Maryla		irtment of He tificate of D			giene _{Reg. No.} 200	5 06777
Physic	ian	1. Decedent's Name (First, Middle, L	.ast)				2. Date of De. Month	ath Day Ye	3. Time of Death
/Med		LILLIE MALIND						25, 2005	1605 P ^M
Exami	ner	4a. Facility Name (If not institution, g JOHNS HOPKINS H	ive street and number) IOSPITAL		4b. City, Town, or I BALTIMO	RE CITY		4c. County of D	eath
Funera Director		214-50-4098	Sex 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 4-25-1	y, Year)	Birthplace (State or Foreign Country) OUTH CAROLINA
and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Maryl f sho	ř	MD. N/A		BALTIMOR	E				1 Yes 2 □ No
r 28e	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
th wit	aD	709 N. STREEPER	ST.		21213			USA	
be filed within 72 hours after death with the Maryland hal Hygiene. do other than "neturel", or Items 23a or 28e-f show event. Ite Madical Exertires must be notified at	by Funeral Director	11. Marital Status 1 ☆ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Year or Dates:	- 1	Vas Decedent of His f Yes, specify Cuban I ☐ Yes 2☐ No	panic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		merican Indian, /hite, etc. BLACK
hin 72 hou s. in neture Modes E	Completed I	15. Decedent's (Specify only highest (Secondary (0-12)	Education	(Give	lent's Usual Occupat kind of work done di DO NOT use retired)	iring most of work	king	16b. Kind of Busine	ss/Industry
d with	m o	-10-		NURSI	NG ASSIST	ANT		HEALTHC	ARE
z snould be filed withir and Mental Hygiene. Is marked other than eumatic event, It e M.	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
and Mental marked o umatic eve	2	HARRY E. GADDY					MAE McCO		
th and Mer 7 Is marke treumatic		19a. Informant's Name/Relationship			•			er, City or Town, Stat	
1 an Heall em 2 ther		JESSIE MILLER(S					MURE, M	ARYLAND 2	
		14 Burial 2 Cremation 3 4 □ Donation 5 □ Other (Special Control of Control	Millioval Ilolli State		sition (Name of natory or other place	!	2225		
그 문문 등		21. Signal uneral Service/Lio			CEMETERY Name and Address	-3-3 s of Facility Dut	2005	BALTIMORE	MARYLAND
Depa Impo		1 Country	() AR						RYLAND 21217
		23a. Parti. Enter the disease, or co	mplications that caused the d						Approximate
Fnysician		short, or heart failure. List on Immediate Cause (Final		naconie A	therosclero	his and	prine and la	a disiner	Interval Between Onset and Death
/Medica		disease or condition resulting in death)	aDue to (a as a cons		MAUSCIEND	ne ewsu	v vu Xu ia	visuse	
Examine									
	ne.	Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):					
physician and the burial-transit	Examiner	that initiated events	с						
ian a	E	resulting in death) Last	Due to (or as a con:	sequence of):					
shysic the b	dical		d						
	0	IF FEMALE:	23c. If yes, outcome of pre	anancy				23d. Date of	dolinos
atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
by the a	ysi	1 Yes 2 No 9 Unknown	9□ Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
igned b	by Pi	Part II. Other significant conditions	s contributing to death but not	resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
been sig should b	q pe						101	fes 2□No 3□	Probably 4 Nknown
ate has been signed by the attending page 2 should be detached for use a	Completed						24a. Was		autopsy findings available
te has	mo							rmed? death	
	e)	25. Was case referred to medical				26. Place of Deal			34.10
direc	To B	examiner? 1 XYes 2 No	Hospital: 1 Inpatient	ER/Outpatier	t 3 DOA Other	r: 4 Nursing Ho	ome 5 Resid	dence 6 Other (S	pecify)
h. After thi funeral c		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time or Injury	28c. Injury Work	at ?	28d. Describe I	now injury occurred	
er death.	Certification:	2 Accident investigat	t he			es 2 No			
fter d	H	3 Suicide 6 Could not determine		At home, farm, str <i>ecify)</i>	eet, factory, office		28f. Location (3 City or Tox		Rural Route Number,
within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		20.00.77							
within 24 hours after deatl To the Funerel Director: completely filled in by the	edical		Physician: To the best of my aminer: On the basis of exame and manner stated.						
within 24 hours afte To the Funerel Dir completely filled in	Med	29b. Signature and title of certifier	and mainly stated.		29c. License	number		29d. Date signed (Mo	onth, Day, Year)
≱ ⊢ ŏ		Variat &	with rell air		OCIN	CT.		FEB. 28,	2005
1		30. Name and address person wh	no completed cause of death (Item 23a) (Type	OCM.	IE.			
5		i	ecthail, ms		,	n Street	Balti	more. Mary	vland 21201
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature				TIGIL 9	June 21201
Regis	trar	MAR 02	2005 May	H	Frank)				
ИН 17 Rev 1	2001	C.A.		7	1				
				ORIGINA	\L				

		1	For State Registrar	_	epartment of Health and Certificate of Death	Mental Hygien	-000 00110	
	Physicia		1. Decedent's Name (First, Middle, Last)	HILL	CR		ay Year 7.54 A M	
	/Medic Examin	al	Aa. Facility Name (If not institution, give s	, , , , , , , , , , , , , , , , , , , ,	4b. City, Town, or Location of Dea		c. County of Death	
			North Anne Gru 5. Social Security Number 6. Sex	ndel Hospital 7. Age (In yrs. last birthe	GRA BUTNI	S O Date of Birth	INNE OYUNGEL 9. Birthplace (State or Foreign	7
	Funeral Director			M 2□F 60 Yr	Months Davs Hours Mil	1. 8-23-19	144 NORTH GOOTNA	
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits	
	8a-f sh	ector		undel Sever		100.0	1 ☐ Yes 2 ☑ No	
	3a or 2	Dire	10e. Street and Number 7802 Manet	Way	10f. Zip Code 21144	Ür	nited States	
	er deati Items 2 nar.ma	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 □ No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
036	hours after death with the Maryland tural, or Items 23e or 28e-f show al Examinatinust be redified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	It Yes, Give Year or Dates: 1965-11	1 ☐ Yes 2 No Specify:		Specify: Black	
21215-0036	in 72 h n "natu redice	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Decedent's Usual Occupation Give kind of work done during most of w life. DO NOT use retired)	rorking 16b.	Kind of Business/Industry	
	se filed within al Hygiene. I other than " want, the Mg.		17. Father's Name (First, Middle, Last)	3	Driver Vehic	ame (First, Middle, Maide	Hostal Services	
land	uld be fi Mental H rrked ot rtic ever	To Be	CLYCE 1	Fill	FLO	ra Hic	Ckman	
Maryland	and I smalls ma		19a. Informant's Name/Relationship (Ty)	196. Print) 196. I	Mailing Address (Street and Number or I	1 6 .	or Town, State, Zip Code)	
	os 1 and of Health litem 27 r other tr		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R	20b. Place of I	Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		'4 □ Donation 5 □ Other (Specify) 21. Signafure of Funeral Service License	urling	Ton Cemetery 31 22. Name and Address of Facility	10/05 ar	lington, va. 420 H Street ne.	
Ba	Department Department		Tisa UN	2000 yww	B.K. HENRY TU	nural Home	Wash., DC. 20002	2
ſ,			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not be cause on each line.			Approximate Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	Lue to (or as a consequence of		Disease	years	
	Examiner	<u>-</u>	Sequentially list conditions,	Eus lb or as a consequence of):		Years	
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hypercholes	Evalenia		year	
68760,	cate be executed physicien and the burial-transit	al Ex	resulting in death) Last	Diabetes me	ellitus.		Years	
_		Medical	IF FEMALE:					
Box	The law requires that the death certificate has been signed by the attending plyage 2 should be detached for use as it	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
P.O	res that the de igned by the a be detached		9 ☐ Unknown Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?	
ords	w requires been sign should be	ted by	Depression, Post	traumatic Stress]	hrsoder	1 ☐ Yes	2□No 3□Probably 4□Onknown	1
Records,	The law rate has be page 2 sh	Completed	,			24a. Was an autopsy performed?		3
Vital	Physician: The rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one)		
of	Phys r this ral di	n: To	1 ✓ Yes 2 ☐ No 27. Manner of Death 1 latural 5 ☐ Pending	28a. Date of Injury 28b. Ti	Datient 3 DOA 4 INDISING	Home 5 Residence 28d. Describe how in		
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, far	M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number,	_
<u>S</u>	ital or A rs after al Directed in by	Certi	4 Homicide determined	building, etc. (Specify)		City or Town, Sta		
	To the Hospital or Atten Within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and pla for investigation, in my opinion, death oc	ace, and due to the cause courred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)	
	within 2. To the I complet	Me	29b. Signature and title of certifier	Deputy	29c. License number	\ \ \ .	Date signed (Month, Day, Year)	
	6/		30. Name and address of person who so	ompleted cause of death (Item 23a) (D31473		av 1, 2005	-
	1		PATRICE A TOYE, N	no 4565 Hemloc	k Come Way Elli	cott City nu	021042	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005 Medica	or appear			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day Year 4:45 PM 02 INETHIER HARRISON 25 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Sinai Hospital 0/ Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 2 9. Birthplace (State or Foreign **Funeral** 1 M 2KN Director 66 Yrs. SOUTH CAROLINA 213-36-1901 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director XXYes 2 No MARYLAND N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 2554 OSWEGO AVENUE 21215 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 Yes 2 No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 8 lack, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 12th grade RET. NURSING ASST. HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file Health and Mental Hy am 27 is markad oth Be JOHN O CANNON JESSIE HUTCHINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health all Important: If itam 27 is any injury or other traconce. Richard J. Harrison Sr/Husband 2554 Oswego Ave., Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MARYLAND GARRISON FOREST 03-04-05 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Vallar 1206 W NORTH AVENUE 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8 etween Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) days /Medical Due to (or as a consequence of): Examiner difficile colitis Clostridium day Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No autopsy performed? 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check on one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours at To the Funaral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tyle of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES 000 2 25 2005 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vishnupriya 2401 West Belvedere Avenue, Baltimore MD 21215 Kittane 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Harrison

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Patient known

2005

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)			For	State of Ma	•	partment of H		lental Hygi	ene	06700
			For State Registrar		Ce	ertificate of l	Death	,	g. N6- U U U	00100
	Physicia	an.	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Elliott		Lamar	Не		Februar	y 18, 2005	
ì	Examin		4a. Facility Name (If not institution, giv				Location of Death		4c. County of Death	
			Prince George's H	-		Cheverly			Prince Ge	
	Funeral Director		5. Social Security Number 220 – 19 – 5398	Sex 7. Age M 2□F	e (In yrs. last birthda 22 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV . 1	Year) 9. Birth Cou	place (State or Foreign Intry) land
	D.		Usual Residence of Decedent							40d Jacida City Limita
	uylar show	_	10a. State 10b. County	D.C.	10c. City, Town or					10d. Inside City Limits 11 Yes 2 □ No
	Se-f s	cto	Md.	PG	Seat Pl	easant				
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	23a	rai	7018 Graig Ct.			20743			SA	
	tems	ne	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H if Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or l	by Funeral Director	1X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐴 N	10	1 ☐ Yes 2 No	Specify:		Specify: Bla	ick
8	hour urel	d b	15. Decedent's E	Year or Dates:	162 Dec	cedent's Usual Occup	ation	1	6b. Kind of Business/Ir	
,	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-f show he Medical Exameter must be notified at	jete	(Specify only highest gr.	ade completed)	(Gi	ve kind of work done of the NOT use retired	during most of work	ring		
Maryland 21215-0036	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	k Driver		P:	rivate In	dustry
2	e filed at Hygie other vent.		17. Father's Name (First, Middle, Last	+1			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
an	d be ental ked c	To Be	Thomas L. Heb	ob			Delores	s Townes	S	
2	2 should be and Mental Is marked o	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Rur	al Route Number,	City or Town, State, Zi	ip Code)
Ž	and 2 tealth a mm 27 is her tree		Delores Townes	(Mother)	6325	Carrino	ton Ct.	Seat Pl	easant.Mo	7 20 7/3
<u>5</u>			20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place	ce)		0c. Location - City or T	
E G	Page: ento nt: If ry or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Harmon	y Mem. C	em. 2/28	3/2005La	andover,	Maryland
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of		21. Signature of Funeral Service Lice			22. Name and Addre	ss of Facility $ar{\mathbf{T}}$	ri-State	F/S/Inc	•
m	Depa Impo any ir		Jam 9/	mest		912 Thir	d St.N.V	W.Wash.I	O.C. 2000	1
	_		23a Part1. Enter the disease er conshock, or heart failure. List only	aplications that caused	the death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	5 avsie	1 wac	W.S		
	Examiner									
	10-	ĕ	Sequentially list conditions, a y leading to immediate cause. Enter Underlying Cause (Disease or injury that believed excepts)	b. Due to (or as	a consequence of):					
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ó	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
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68	leath certificate attending phy I for use as the	Physician/Medi	IE CEMALE.						-	
Вох	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopic pregnancy	V		23d. Date of deliver Month	very Day Year
	deal	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death	5 Other (specify)			WORKI	Day
P.0	that the de led by the a detached	Å.	9 🗆 Unknown					Office Didash		the source of death?
	res tha igned be del	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	e underlying cause giv	en in Part I.		acco use contribute to	babiy 4 Unknown
D'C	w require been si should I							1 □ Ye	s 2 □XNo 3 □ Pro	Dably 4 Donkhown
၁၁	as be	Completed						24a. Was ar autopsy	/ prior to c	opsy findings available ompletion of cause of
æ		OT			v.			perform 1 Yes 2	led? death? □ No 1 2 Yes	2□ No
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5	hysici nis cer I direc	10	1 X Yes 2 □ No	Hospital: 1 Inpatie	ent 2 ER/Outpa	tient 3 DOA	1er: 4 ☐ Nursing H		nce 6 Other (Spec	sity)
	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time Injur	y Wo	rk?	28d. Describe ho	col at f	
0	endil eath. or: A he fu	ati	2 Accident investigation	0 (0(0	5 6:50		Yes 2 No	Subje	ctshot	
Division	l or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined	200. Place of III	c. (Specify)	street, factory, office		City or Town		
	ital c				Loca	Street		Carringto		
	Hospital or Attending 24 hours after death. Funeret Director: After tely filled in by the fune	ical	(Check only 2X Medical Exa	miner: On the basis of	f examination and/o	eath occurred at the ti r investigation, in my o	me, date and place, ppinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	Ko the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the I	Medical	One Signature and title of certifier	and manner st	Bred	29c. Licens	se number	20	d. Date signed (Month	Dav. Year)
	الرقاع الم	2	29b. Signature and title of certifier	(200	1				ebruary 19,	
1	7-11		Lauden	allano	na		CME	1.0	17,	
1	1		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print) 111 P	enn Stree	t Balti	more, Mary	land 21201
			31. Date filed (Month, Day, Year)	32 Bad	rar's Signature				incres riciry.	21201
	St: Regist	ate rar	MAR 02	2005	CHEN S.	pole				
	3.0.			and the same of th		- /				

			For State	State of Ma		d / Depa	artment o					· Can	005	06781	
			Registrar			Cer	uncate	OI L	Jeani			g. No.			_
	Physicia	an	Decedent's Name (First, Middle, Last)								2. Date of Deatl Month	Day 28	Year	3. Time of Death	
	/Medic		MARY EBERSTAI	OT HARP	ER						FEB.			01;10p ^M	
	Examin		4a. Facility Name (If not institution, give				4b. City, To						County of Death		
П			308 GOLF COURSI	E RD.			OWIN					BA	LTIMOR	₹E	
	Funeral Director		210-40-0312	144 - 157 -	ln yrs. la	ast birthday) Yrs.	If Under 1		If Under: Hours	Min.	8. Date of Birth (Month, Day, 02/18/	^{Year)} 192	9. Birth Col. 4 MARY	place (State or Foreign intry) (LAND	1
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation						T	10d. Inside City Limits	_
	eho	ħ	MD BALTIMOI	ਕ			S MIL	LS					-	1 ☐ Yes 2 XNo	
	he M	Director		(L		711110	10f. Zip C				1/	3a Citia	en of What Cou		_
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or liems 23e or 28a-f ehow event, the Marical Examilitation at the marilland.	ä	10e. Street and Number 308 GOLF COURS1	מק ז				111	7				SA	and y :	
	s 23	Funeral		12. Was Decedent 6	Ever in 119	2 112 1				nin? /Sno	offy Vac or No		4. Race - Amer	ican Indian	_
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36	, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	40		1□Yes 2	X No	Specify:			5	Specify: WH]	TE	
0	hour ture	edk	15. Decedent's Edu			16a, Decec	dent's Usual (Occupa	ition				d of Business/I		_
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0	Hygie Hygie other ant, II		17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, N	faiden S	iumame)		_
a		o Be	FERDINAND EBERS	ጥልኮጥ					MAR	Y TC	NGUE				
2	2 should be fand Mental I is marked o	ဥ	19a. Informant's Name/Relationship (T)			19b. Mailin	na Address (5	Street a			l Route Number,	City or	Town, State, Zi	ip Code)	_
Maryland 21215-0036	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		LAWRENCE HARPE		(מו						OWING	-			d
	1 and Health em 27 ther tr		20a. Method of Disposition	(HODDIII)	20b. Pl	ace of Dispo	sition (Name	of	1				ation - City or T		-
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Baltimore,	교문문문 .				51		Name and				7 2003	OWI	NOD II.	LBBO, IID.	
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М			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ne cause on each lir	10.	. Do not ent	er the mode t	or dyling	g, such as	cardiac o	r respiratory arre	;SI,		Interval Between Onset and Death	
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ı	LAdillilei	_	Sequentially list conditions,	o											
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	and trans	cam	that initiated events resulting in death) Last	Due to (or as		iones of):									_
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x 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE:	22a Musa sutsama		2011									
Вох	ath c ttenc or us	ian/	23b. Was decedent pregnant in the past 12 mg/hths?	3c. If yes, outcome	2 🗌 Fetal	death 3	Ectopic preg					23	3d. Date of delive Month	very Day Year	
<u>.</u>	the a	SIC	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5∟	Other (spec	orfy)							
<u>о</u> .	that the de ned by the a detached i	Phy	Part II. Other significant conditions co	atributing to death b	ut not resu	ulting in the u	nderhina cau	ISO GIVE	n in Part I		23a Did tob	acco us	e contribute to	the cause of death?	
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ita	ysicien: is certific director,	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only on	5)			
	<u>> .00</u> D	户	1 Yes 2 No	lospital: 1 ☐ Inpatie	nt 2 🗆 I	ER/Outpatier	nt 3 DOA		4 LI NU	-	me 5 eside			ify)	Į.
Division of	Attending Physicien: or death. ector: After this certification in the funeral director, I	ii.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	f 280	c. Injury Work	(?		28d. Describe ho	w injury	occurred		
000	endin sath. or: A he fu	atle	2 Accident investigation				М	101	Yes 2□	No _					
ž	r Att	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injusting, etc.	ury - At ho c. (Specify	me, farm, str	reet, factory, o	office		1	28f. Location (Str City or Town		Number or Rui	ral Route Number,	
	talors aft	Certification;													
	lospi hou uner	edical	29a. Certifier 1 ✓ Certifying Phy (Check only 2 ☐ Medical Exami	sician: To the best	of my knov	wledge, death	h occurred at	the tim	e, date an	d place, a	and due to the ca	use(s) a	and manner as	stated. to the cause(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ledi	one)	and manner sta											
	To To I	Σ	29b. Signature and title of certifier	71.	1	^	29c. 1		number		29		signed (Month		
	110	/	I will	- Th			150	L	42	70		3	-1-0	/ \	
	1700		30. Name and address of person who c												
1		III.		NNELL M			N. CH	IAR	LES	ST.	TOWSON	, MD	2120	04.	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Figistr	ar's Signa	ture	Cart 1								
	Registr		MAR 0 2 20	OF 1880-4											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day -Month **Physician** ebrua Sarah A. Hale /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris at Mercy Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 27, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs. Maryland 71 219-28-9292 **Director** Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show nust be notified at 1∏Yes 2∏No Director MD Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 3556 Poole Street 21211 Itams 23g USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status is 1 and 2 should be filed within 72 hours after do of Health and Mentel Hygiene. Item "natural", or Itam tiem 27 is marked other than "natural", or Itam other traumatic avant, Ita Medical Exemples. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 nurse health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Francis Greeley Katherine Marie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2507 Karen Way Westminster, MD 21157 Cathy Williams/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State
4 X Donation 5 Other (Specify) 21. Signiture of Eunoral Sarvice Licensee

Rohald S. Wade, Director

Baltimore, MD 21201

21. Signiture of Eunoral Sarvice Licensee

Rohald S. Wade, Director

Baltimore, MD 21201

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Rohald S. Wade, Director

Baltimore, MD 21201

21. Signiture of Eunoral Sarvice Licensee

Rohald S. Wade, Director

Baltimore, MD 21201 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Immediate C ... e (Final disease or condition resulting in death) Physician 100 conter /Medical Due to (or as a consequence of):« **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2FINO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: To the Hospital or Attanding I within 24 hours after death. To the Funaral Diractor: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 Homicide Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12412005 30. Name and address of person who completed aug of death (Item 23a) (Type, Print) Paul 301 21 CIVILD 323Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2 2005 Registra

			State of N 1- State Amend Item 18 per fh	Maryland / Depa G841 3-2-05	artment of H	lealth and M	Mental Hygi	ene 005	06783
	Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		FREDA		HONIG		FEBRUARY	^{Day} 27, 200!	5 7:05 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number		4b. City, Town, or	Location of Death		4c. County of Dea	
	•		FREDERICK VILLA NURSING 5. Social Security Number 6. Sex 7.	HUML Age (In yrs. last birthday)	If Under 1 Year	BALTIMO If Under 24 Hrs.		100	ALTIMORE
	Funeral Director		5. Social Security Number 149-28-6500 1	97 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV . 6, 19	907	rthplace (State or Foreign Sountry) HUNGARY
	rland iow		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar.	tor	MD HOWARD	COLU	MBIA				1 □ Yes 2 1 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	Country?
	ath w	rai	10430 OWEN BROWN ROAD			21044			USA
	tams	Funerai	11. Marital Status 12. Was Decede Armed Force		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	', or I	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ 3 🏋 Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
8	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28a-f ahow The Mudical Examination Inditional at		15. Decedent's Education	16a, Dece	dent's Usual Occup	ation	10	5b. Kind of Busines:	s/Industry
215	C 2 30	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	life.	kind of work done of DO NOT use retired	during most of worl ()	king		
21215-0036	filed within Hygiene. Other then rent, the Man	Completed	Elementary/Secondary (0-12) College (1-40	HOME	MAKER		(WN HOME	
nd	0 0 0 0	Be (17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		1
yla	Men Men arke	T ₀	ADOLPH 19a, Informant's Name/Relationship (Type, Print)	HERSHKOWI			Esther K	Lein City or Town, State,	-KLINE
Maryland	12 s h ar 7 ia trau		RUTH COHAN / DAUGHTER		•			BIA, MD 21	
	1 a		20a. Method of Disposition	20b. Place of Dispo	osition (Name of			Oc. Location - City o	
Ë	0 0 == =		1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from Sta 1 ☐ Donation 5 ☐ Other (Specify)	LAKESIDE	matory or other plac MEMORIAL		/2005	MIAMI,	FL
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		2. Name and Addres			N & BROS.	
m	P P E S	. 11	Rotet John	8	900 REIST				MD 21208
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Pnysician	0		o-pneumonia					Onset and Death One Week.
	'/Medical Examiner		resulting in death) Due to (or	as a consequence of):					
	LAMITIME	<u>.</u>	Sequentially list conditions, b. Senile	e Dementia as a consequence of):					Years.
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. List of Johnson Grause (Disease or injury	as a consequence or).					
_ III.	al-trai	Examine	that initiated events C.	as a consequence of):					
8760,	death certificate be executed e attending physician and of for use as the buriat-transit		d.						
9	tificat ig phy as thi	ledi							
Вох	eath certific attending p	N/us	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the property of t		Ectopic pregnancy			23d. Date of de	
	ed for	sicis	1 Yes 2 No	at time of death 5	Other (specify)			Month	Day Year
P.0	that the de ned by the detached	Physician/Medical	9 Unknown			as in Doct !	230 Did tobo	and use contribute t	to the cause of death?
ds,	98	by	Part II. Other significent conditions contributing to death Coronary Artery Disease	a par nor resulting in the a	nderlying cause give	en in Fait i.		••	robably 4 Unknown
Ö	w requir been si should I	etec	Hypertension						
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la		e Co	25. Was case referred to medical			OS Plane of Poor	1 ☐ Yes 2 €	No 1 □ Ye	s 2⊠ No
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ı of		Ë	27. Manner of Death 28a. Date of I				28d. Describe how		ouny)
<u>io</u>	Attending or death. ector: After by the funer	atio	2 Accident investigation	Day rear) Injury		Yes 2□No			
Division	il or Attendater death Director:	Certification:		Injury - At home, farm, str etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
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	To tha Hospital or within 24 hours after To tha Funaral Direct completely filled in the complete	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the beside and manner and manner	s of examination and/or in					
	To the To the Comp	M	29b. Signature and title of certifier	4	29c. License			I. Date signed (Mon	
,	0		IV D. Color			D 30469		4	8, 2005.
	01		30. Name and address of person who completed cause on B Vellanki, MD; 9055, C		^{Print)} ∀e, #100,	Ellicot	t City, M	D 21042.	
:-	Sta Registi		31. Date filed (Month, Day, Year) 32. Reg 2095	strar's Signature	is from	e e			

		ı,	Amend Items 2	pe or Print in F 23a per Dr., State of Marylan	3844	hbEnsure All lealth and Me	Copies Are ental Hygiene	Legible.
	Physicia	an	The books of the state of the s			Death	Reg. No. 2. Date of Death Da Month Da	y Year
	/Medic Examin Funeral	al	4a Facility Name (If not institution, give str	1 10 -11	Pital 4b. City, Town,	Hours Min.	B. Date of Birth (Month, Day, Year)	e. County of Death 9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent		y, Town or Location	H	veust 20, F	10d. Inside City Limits
	h the Maryland r 28e-f show inotified et	ector	MD HARA		ABINGDO	DN	100.0	1 Yes 2 No
	23a or 2	Funeral Director	639 FRANS	DRIVE		21009		U.S.A.
2-0036	hours after des turel', or Items	þ	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	.S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spec ban, Mexican, Puerto R o Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: DLACK
21215-0	hin 72 an "net	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		life. DO <u>NO</u> T use retir	during most of working	16b. I	Rind of Business/Industry PRIVATE
Jand 2	s 1 and 2 should be filed wit f Health and Mental Hygiend item 27 is marked other thi other treumetic event, the	o Be C	17. Father's Name (First, Middle, Last) CONRAD W. H	ARRY		18. Mother's Name ((First, Middle, Maide EA Hy	n Sumame) ACINTH
Mary	and 2 shou saith and M n 27 is mar er treumei		19a. Informant's Name/Relationship (Type	Print)	19b. Mailing Address (Stree	and Number or Rural	Route Number, City	or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr. 2008.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	moval from State	Place of Disposition (Name of emeter), crematory or other place. LED HEART CE, 22. Name and Addi 4915 VIIA	YETERY 2.25	THN C GA	TUMBE, MARYLAND ENE FUNERAL HOME MARYLAND 21212
760,	Priyacian /Medical Examiner e privilege privil	cal Examiner	23a. Part1. Enter the disease, or samplic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	11 1-	Massive C N N N N N N N N N N N N N N N N N N	ing, such as cardiac or LURC Fat Emboli OCC γ To ρ		Approximate Interval Between Onset and Death DAYS
O. Box 687	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Il death 3 ☐ Ectopic pregnan	су		23d. Date of delivery Month Day Year
ا م	ires that the de signed by the a 1 be detached f	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to the cause of death?
of Vital Records,	sicien: The law require certificate has been si rector, page 2 should I	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 XYes 2 No
Vita	sicien: certific lirector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Ho	espital: 1 Xinpatient 2	ER/Outpatient 3 DOA	26. Place of Death		6 □Other (Specify)
Division of	To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 2 Sould not be	28a. Date of injury (Month, Day Year)	28b. Time of lnjury M 1	ury at 28 ork? □ Yes 2 □ No	8d. Describe how inju	ury occurred and Number or Rural Route Number,
Oiv \	pitel or A		4 _ nomicide		ome, farm, street, factory, office (y) owledge, death occurred at the		City or Town, Star	,
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier 1 Certifying Physic (Check only one) 29b. Signature and title of certifier	er: On the basis of examina and manner stated.	ation and/or investigation, in my	opinion, death occurred	d at the time, date ar	ate signed (Month, Day, Year) 02/17/2005
	Sta	ate rar	30. Name and address of person who core of the second of t	npleted cause of death (Iter	n 23a) (Type, Print)	> Ce Di	ve Ba	Itimore, Ml 2123

		For State Registrar		/ Depa	artment of Health and tificate of Death	Mental Hy	_	0670
Physicia /Medica		1. Decedent's Name (First, Middle, Las	olmes		Johnson	2. Date of Dea Month Februar	ath Day Year	3. Time of Death 6:45 A
Examine Funeral	er	4a. Facility Name (If not institution, give 9818 Woodyard Ci 5. Social Security Number 6. Se	rcle 7. Age (In yrs. las	t birthday)	4b. City, Town, or Location of Dea Upper Marlboro If Under 1 Year If Under 24 Hrs	th	4c. County of Dea	ith
Director	}	250-74-6868 15 Usual Residence of Decedent 10a. State 10b. County	□ M 2X□ F 51	Yrs.		5. 8. Date of Birt. (Month, Da) July 28	3, 1943 Gre	eenville, S
r 28a-f sho	rector	MD Prince (George's Uppe	er Ma	r1boro		10g. Citizen of What C	TV☐ Yes 2 ☐ N
death with	Derai D	9818 Woodyard Cin	12. Was Decedent Ever in U.S.	13. <u>V</u>	20772 Vas Decedent of Hispanic Origin? ('Yes, specify Cuban, Mexican, Pue		USA	
72 hours after death with the Maryland natural; or Items 23a or 28a-f show alsal Exertinet roust be notified at	d by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	☐ Yes 2☐ No Specify:		Specific	
within ane. Ithan	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give I life. D	ent's Usual Occupation kind of work done during most of wo NOT use retired) Meat Wrapper	rking	Wholesal	
be fill that H dott	To Be C	17. Father's Name (First, Middle, Last) Lewis Holmes				me (First, Middle, ampton		
		19a. Informant's Name/Relationship (T) Dora Holmes (N 20a. Method of Disposition	Mother)	98	Address (Street and Number or R Number of R	le Upper	Marlboro,	MD 20772
Page ment o ant: If ury or		1 Burial 2 Cremation 3	Mose	Chap	el Cemetery 2-19	-05	Pelzer, S	
permit. Departition in the permit is permit in the permit		23a. Pant Enter the disease of comp shock, or heart failure. List only o	doold lications that caused the death		Name and Address of Facility C. Franks Chap 15 Augusta St. (r the mode of dying, such as cardia	Greensvil	<u>le, SC 296</u>	Approximate
Prysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		C once of):	VARIAN CAN	CEL		Interval Between Onset and Death
e be executed	cal Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of the consequent of	ice of):	AKCINO MATOS	ີເຮ		-
death certifica e attending ph of for use as th	Pnysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	ath 3 🗆	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
igne bed	2	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the und	derlying cause given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
The ate h page	Completed					24a. Was a autops perform	y prior to o ned? death?	topsy findings available completion of cause of
hysicithis certail direct	0	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation		/Outpatient b. Time of Injury	Oth		ence 6 Other (Spec ow injury occurred	sify)
al or Attanding s after death. Il Diractor: After d in by the fune	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree		28f. Location (St. City or Town	reet and Number or Ru I, State)	ral Route Number,
he Hospi n 24 hou ha Funar pletely fill	edical	one)	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time, date and place sstigation, in my opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
T Too	E	29b. Signature and title of certifier	Joskus, MP		29c. License number P4316 &		Pd. Date signed (Month February 1	
6		30. Name and address of person who co Melvin W. Gaskins,	7831 Bell	le Poi	_{rint)} Int Drive, Greenl			
State Registra	٠.	31. Date filed (Month, Day, Year) MAR 0 2 2	32. Registrar's Signature	y. A	Δ.			

			ricuse	State of Marylan				•	_	
			1 - For State Registrar	Otate of Marylan		tificate of		Wichtai i iy	Reg. No. 2 0 0 5	06786
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physici /Medio		MARIAN	\mathcal{M} .	Je	NKIN	/S	O2	Day Yeer 19 200	5 2:40 AM
	Examin		4a. Fecility Name (If not institution, give		_	4b. City, Town, o	r Location of Deat	. 11	4c. County of Dea	ath
			5. Social Security Number 6. Se	COPAL Life (BA CAM	MitCI	hellVille If Under 24 Hrs	· Md	PRINCE	GEDRGES
Н	Funeral Director		,	x 7. Age (In yrs. 7	Yrs.	Months Days	Hours Min.		y, Year) Min	rthplace (State or Foreign country) nesota
			Usuel Residence of Decedent	,,,,				00/04/	M'7 FILL	
	show	ř	10a. State 10b. County	\circ	y, Town or Lo					10d. Inside City Limits 1 Yes 2 No
	28a-f	Director	10e. Street and Number	seorges Mi	tene	IVIIC,	Ma 2	0721	10g. Citizen of What C	
	or death with the Marylan terna 23e or 28a-f show	١٥		: RAJ P1		101. Zip Code	471		USA	ountry r
	ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of H	dispanic Origin? (S an, Mexican, Puer	pecify Yes or No		
ထ္	or its	Fu	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2X No If Yes, Give		Yes, specify Cuba ☐ Yes 2 No	an, Mexican, Puer Specify:	to Hican, etc.)	Black, Wh Specify: W	
003	be filed within 72 hours after death with the Maryland tal hygiene. Id other than "natural", or itama 23a or 28a-f show other than "natural", or itama 23a or 28a-f show event. If a Medical Exami as I rutal be indiffed at	d by	3 Widowed 4 Divorced	Year or Dates:						
15	in 72 "nat	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	(Give)	ent's Usual Occup kind of work done OO NOT use retired	during most of wo	rking	16b. Kind of Business	s/Industry
212	f within piene. r than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)			ical		federal	government
פ	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)	-			18. Mother's Nar	me (First, Middle	Maiden Sumame)	89.021
<u>ylaı</u>		To	Lincoln Herbert	Jenkins				Strong		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (T) Lloyd Jenkins/nep						er, City or Town, State, ar, Seattle	
	s 1 and 2 should f Health and Mer itam 27 is marks other traumatic		20a. Method of Disposition			sition (Name of	CII Dake	Date	20c. Location - City o	
Baltimore,	90 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 14 🛣 Donation 5 ☐ Other (Specify,	Removal from State	emetery, crem	atory or other plac	ce)			
altir	# 문 원 등 .		21. Six tur of Euneral Invice Licens		c ²²	Name and Addre	ss of Facility	4 655 W	Baltimore	Stroot
m	Depa Impo Impo Any ii		1 munt	Il Il		ltimore,			Daitimore	Screet
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death ne cause on each line.			0			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	chranic	Oper	(ruch 11	10 / w/.	mange	Disease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					
	in the second	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):			101		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o Ô	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):			· · · · · · · · · · · · · · · · · · ·		
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x 68	ding p	/Med	IF FEMALE:	23c. If yes, outcome of pregnal	nev					
Вох	atten atten	Physiclan/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)	′		23d. Date of de Month	livery Day Year
P.O.	that the de ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	The law requires that the death certifica tie has been signed by the attending ph age 2 should be detached for use as th	by P	Part II. Other significant conditions co	\ .	_		en in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
ord:	w require been sig should b	ted	177100 4 11	1/2/2-		1207/10		10`	Yes 2□No 3□P	robably 4 Donknown
ecc	law r las be	Completed	1075 No 10/2	10191	er 7	Artu	1	24a. Was	osy prior to	utopsy findings available completion of cause of
<u> </u>		Col	gyease					perfo 1 Tes	rmed? death?	2 □ No
Vital Records,	Physician: The law rthis certilicate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		aCI DOA Oth		ath (Check only o		
ō	> v 0	: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injun	y at		dence 6 Other (Spe	ocify)
ion	Attending r death. ector: After by the fune	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	k? Yes 2 □ No		, ,	
Division of	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number or R	ural Route Number,
	ital or A rrs after ral Directled in by			Danaing, cit. (openin)						
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, death tion and/or inv	occurred at the tinestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licensi	e number		29d. Date signed (Mon	h. Dav. Year)
	F 3 F ŏ		I clos the	- Mo		D 20	5079		<u> </u>	,
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	rint)	0		m ma 2	27916
			Don 14. You lara			te calv.	0 1 (500)	Town	4	
	Sta Registr		31. Date filed (Month, Day, Year)	3 Registrar's Signat	ture	. D				

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland	•	artment of Health and tificate of Death	d Mental Hygien	0.2005 0670	
	Physici /Medio Examir	al.	Wanda Belle Kinle 4a. Facility Name (If not institution, give s			4b. City, Town, or Location of D	February 2	21, 2005 03:40A.M	
	Funeral	ler	Harford Memorial H 5. Social Security Number 6. Sex	ospital 7. Age (In yrs. le	ast birthday) Yrs.	Havre de Grace	Hrs. 8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign	
Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Exam net must be notified at once.	_	5 61 – 22 – 2057 Usual Residence of Decedent 10a. State 10b. County	86	, Town or Lo	cation	05/28/1918	10d. Inside City Limits	
		Funeral Director	MD Harford 10e. Street and Number 487 Amelanchier C	ourt	l Air	10f. Zip Code 21015		1 ☐ Yes 2 🗖 No itizen of What Country?	
		þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin's Yes, specify Cuban, Mexican, Pour II ☐ Yes 2X No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
		To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give life. i	tent's Usual Occupation kind of work done during most of DO NOT use retired)	working	Kind of Business/Industry W York Food & Deli	
			17. Father's Name (First, Middle, Last) Joseph B. Dennis 19a. Informant's Name/Relationship (Tyj.	ne Print)		18. Mother's	Name (First, Middle, Maide) Viola Nader Rural Boute Number, City		
			Peggy M. King (da 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	ughter)	489		rt - Bel Air,	Maryland 21015 .ocation - City or Town, State	
Baltimore,			4 □ Donation 5 🕅 Other (Specify)	Entombment Hol	22	. Name and Address of Facility	E. F. Lassahr	ltimore, Maryland n Funeral Home, P.A. e, Maryland 21087	
	Pnysician /Medical	23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Typical disease or condition Typical disease or condition							
I Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						
		e Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc				use contribute to the cause of death?		
			25. Was case referred to medical			00 81	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 127 Yes 2 No	
		0 8	25. Was case referred to medical examiner? **XXYes 2 \sqrt{No}** Hospital: 1 \sqrt{Inpatient} 2 \overline{\text{MERVOutpatient}} 3 \sqrt{DOA} Other: 4 \sqrt{Nursing Home} 5 \sqrt{Residence} 6 \sqrt{Other} (Specify)						
		Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	iry occurred	
			4 Homicide determined 288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)						
		edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
		Me	29b. Signature and title of certifier Panels Knithau, M.O.			0.00		ate signed (Month, Day, Year) bruary 22, 2005	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pame & E - Southall, M.D. 111 Penn Street Baltimore, Maryland 21201						
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure Ju	Enrie			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 06788 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** James E. Lewis 1224 PM February 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Agnes Inmore Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number **Funeral** Days Months Hours 1**⊠**M 2□F Director 219-03-6326 91 3-29-13 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show traumatic event, the Modical Examiner aust be notified at Yes 2 □ No Director Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1611 St. Stephens Street Items 23a 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □Yes 2 X No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 ₩idowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Food Service 12th grade Federal Reserve Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward Lewis Clara Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sl Department of Health and Important: If item 27 is n any injury or other traun 703 St. Dunstans Rd., Baltimore, Md. Joanne Anderson granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 Burian 2 Cremation 3 Removal from State
4 Conation 5 Other (Specify) Md. Nat. Mem. Pk. 3-1-05 Laurel, Md. 21. Signature Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. 23a. Par 1. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, stoc., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeria e Cause (Final dise tser r condition resu tir g in death) Atherarelerote Pnysician ardiavascular Dispose YROUS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2 □ No 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | TR/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier MISICIO 701 completed cause of de h (Item 23a) (Type, Print) 30. Name and address of person who 0 State

Registrar

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		Ľ	1 - For State Registrar	State of M	laryland /		artmen rtificat			and M		iene _{eg. No.} ()05	067	89
	Physicia	an	Decedent's Name (First, Middle, Lass HUGH LEE	t)							2. Date of Deat Month Februar	Day	, 2005	3. Time of 0	Death P M
	/Medic Examin		4a. Facility Name (If not institution, give					Town, or REDEI	Location o	of Death	1 001 401	4c. Co	unty of Death	1	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 543-03-4565 Usual Residence of Decedent	9X 7. A	nge (In yrs. last b	yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, September	Year)	Cou	oplace (State or untry) Orego	_
	yland		10a. State 10b. County		10c. City, To	wn or Lo	ocation							10d. Inside City	
	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or Items 23a or 28a-f show avant, the Medical Ever it writing by retified and	Funeral Director	Maryland Frederic	k	Fre	eder	1							1 XYes	2 🗌 No
	with the same or 2	Ē	10e. Street and Number 10 Fairview Avenue	.			10f. Zip	701			1	•	of What Cou	intry?	
	death	nera	11. Marital Status	12. Was Deceden		13.			spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Amer		
20	s after or Ite	by Fu	1 Never Married 2 Married	1 X Yes 2 □	[™] 1942-		1 ☐ Yes		Specify:	i, Puerto F	tican, etc./		Black, White ecity: As		
9500-61212	2 hours	ed p	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed		1770	a. Dece	dent's Usua	al Occupa	ation				of Business/li		
CLZ	thin 72 e. an "na Media	Completed	(Specify only highest gra	de completed) College (1-4or	r 5+)	(Give life.	kind of wo DO NOT us	rk done d se retired	lu <i>ring m</i> osi)	t of workin	ng			,	
12	led wi tygien har th	Con	17. Father's Name (First, Middle, Last)		5+	Bio	logis	st	10 Mothe	e's Nome	(First, Middle, I			vernmen	t
Maryland	be od o	To Be	Lee Wah						Loc		Sin	vialdeli Sul	пашеј		
ary	d 2 should be th and Mental 7 is marked traumatic av	-	19a. Informant's Name/Relationship (7	туре, Print)	19	9b. Maili	ng Address	(Street a			Route Number	City or To	wn, State, Z	ip Code)	
	ss 1 and 2 of Health a itam 27 is other trai		Charlotte B. Lee/	Wife					venue	_	derick,				
Baltimore,			20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □		e	tery, crei	matory or o	ther place					ion - City or T		
		1	 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen 		Mt. O		et Ger 2. Name an		-		2005			Maryla Church S	
ñ	permit. Departr Importa any inji	9 9	P. Royan 7	nº mile	iano	Ke	eney a	nd Ba	sford	P.A. I	uneral H				
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8760,	certificate be executed ding physician and use as the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or a	s a consequenc	e of):									
Ò	artifica ing ph e as th	Medi	IF FEMALE:									1			
O. Box	death e atter d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death		⊒Ectopic pr]Other <i>(sp</i>					23d.	Date of delive Month	,	ear
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l Reco		Completed by	Cryptogenic	Cun	Hesis			,			24a. Was a autops perform	y ned?_	4b. Were aut prior to co death? 1 \sum Yes	opsy findings at ompletion of call	vailable use of
Vital R	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only on				
	Physic r this c	: To	1 Yes 2 No	28a. Date of In		Outpatier Time o	nt 3 DC	8c. Injury	4 🗀 140		ne 5 Reside			ify)	
lon	Attending death. ctor: Afte y the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	I <i>n</i> jury	М		(? ∕es 2 🔲 i	No					
Division of	tal or Attending Phy s after death. al Diractor: After this ed in by the funeral o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of I	njury - At home, etc. (Specify)	farm, str	reet, factory	, office		2	8f. Location (St. City or Town		umber or Rui	ral Route Numb	er,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	ysicien: To the bes liner: On the basis and manner s	of examination a	lge, deat and/or in	vestigation	in my op	oinion, dea	d place, a th occurre	d at the time, da	ate and pla	ce, and due	to the cause(s)	
	With To Com	Σ	29b. Signature and title of certifier		2/	las	290	. License	number	16	25	9d. Date si	gned (Month	, Day, Year)	
	20		30. Name and address of person who	Completed cause of	death (Item 22)	(Type	Print	11)	04	76		4/6	0/0	13	
	7		Francist. Be	ker, 1	20-3	00	W. 9	Th,	57 .	Fre	Lere.	n	121	701	
200 74	Sta Registr		31. Date filed (Month, Day, Year) MAR 02	2005 32. Reg	trar's Signature	y,	Good	V							

			1 _ State	State of Maryland / Depa	artment of H				5 06790
			Registrar 1. Decedent's Name (First, Middle, Last)	001	incate of L	Julii	2. Date of Dea	eg. No.	3. Time of Death
п	Physicia		Doris Virgin	ia Lambie			Month	Day Yea	ar an
	/Medic		4a. Facility Name (If not institution, give str.		4b. City, Town, or	Location of Death	Februar	y 27, 2005 4c. County of D	10:18
	Examin	er	6603 Bailey Store		Federa			Caroli	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	9.1	DE Birthplace (State or Foreign Country)
	Director		215-05-4794	1 212 F 86 Yrs.	Months Days	Hours Min.	7/22/19		irginia
	p .		Usual Residence of Decedent	140.0%					
	arylar ehow	_	10a. State 10b. County Maryland Caroline	10c. City, Town or Lo Federa	alsburg				10d. Inside City Limits 1 ☐ Yes 2 No
	8e-1	ecto	Tidi y Idiid Odi Oli Iio						
	or 2	Ö	10e. Street and Number		10f. Zip Code	COO	1	log. Citizen of What	Country?
	s 23e	ia d	603 Bailey Store Rd	Man December Francis II C 12.1		632		USA	mencan Indian,
9	72 hours after death with the Maryland neturel; or Items 23e or 28e-f ehow dical Examiner must be notified at	y Fune	Maryland Caroline 10e. Street and Number 603 Bailey Store Rd 11. Marital Status 1 Never Married 2 Married **XWidowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of the status) Elementary/Secondary (0-12) 12 yrs. 17. Father's Name (First, Middle, Last)	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2(7)No If Yes, Give	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XX No	n, Mexican, Puert	o Rican, etc.)		
8	urel',	d b	37\∆Widowed 4 □ Divorced	Year or Dates:					
<u>~</u>	"net	lete	15. Decedent's Educa (Specify only highest grade of	tion 16a. Decec	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wor	king	16b. Kind of Busine	ss/industry
4	withir	ш	Elementary/Secondary (0-12)	College (1-4or 5+) N/A Home	emaker	,		Homemakin	g ~ Own Home
d 2	filed Hygie ther	ပို	17. Father's Name (First, Middle, Last)	N/A Home	SIIIGKCI	18. Mother's Nan		Maiden Sumame)	g OWN HOME
Maryland 21215-0036	ould be Mental Marked o	To Be	Thomas Raymond Taylo	or			e L. Mis		
, Mar	1 and 2 sh Health and tem 27 le m		19a. Informant's Name/Relationship (Type Suzanne Bierman (Dau				Federal	r, City or Town, State sburg, Md	. 21632
nore	ages 1 and of He it: If iten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer 1 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crem Lake View	sition (Name of matory or other place N Mem. Pk	^{в)} 3-2-		20c. Location - City Baltimore	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "neturel; or items 23e or 28e-1 ehow appringury or other treumetic event. The Macical Examiner must be notified at Once.		21. Signar uneral Service Licensee					neral Hom , Md. 212	
	40110		23a. Part1. Enter the disease, or complica	- Jacob					Approximate
Į.	Pnysician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	ext	DISE		est,	Interval Between Onset and Death
Ì	/Medical Examiner		resulting in death)	Due to (or as a convenuence of):					
	ed isit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter undertying Cause (Disease or injury	Due to (or as a consequence of):					
Ć,	execut in and ial-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):					-
8760,	death certificate be executed dather than the attending physician and dor use as the burial-transit	Ical	d.						
9 X	eath certifica attending ph for use as t	/Me	IF FEMALE: 230	c. If yes, outcome of pregnancy				23d. Date of	deliven
D. Box	ne death the atten hed for u	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 □	Ectopic pregnancy Other (specify)			Month	Day Year
P.0	tt by		Part II. Other significant conditions contr	ibuting to death but not resulting in the u	nderlving cause give	en in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Vital Records,	v requires tha been signed I should be det	ed by) XY	es 2 □ No 3 □	Probably 4 Unknown
Seco	aw as b 2 s	Completed					24a. Was a autops perfor	sy prior	autopsy findings available to completion of cause of
=	Th ate pag							No 1□Y	
Vit	yeicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	spital:	othe Othe	20	th (Check only on	10)	
of	shye this al dii	- To	1 Yes 22No	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of	IL 3 DOA	4 Nursing n		ence 6 Other (Sow injury occurred	pecify)
L	ding After funer	lon	Natural 5 Pending	(Month, Day Year) Injury	Work	(? Yes 2 □ No	200. 2000100 11	ow injury occurred	
<u>S</u>	Attending r death. sctor: After by the fune	ical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str			28f. Location (S	treet and Number or	Rural Route Number,
Division	l or A after Dire	ertification;	4 Homicide determined	building, etc. (Specify)	,,,		City or Town		
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	O	29a. Certifier Certifying Physic	cian: To the best of my knowledge, death	h occurred at the time	ne, date and place	, and due to the c	ause(s) and manner	as stated.
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of continer	and manner stated.	29c. License			9d. Date signed (Mo	
)	, y	_	S S S S S S S S S S S S S S S S S S S	(f) run	0 2	7627	78		
	10		30. Name and address of person who com	pleted cause of death (Item 23a) (Type,	Print)	?	5 1-1	4.1	1801
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	April 2)	Scolish	() MI) -1801
•	Registr	ar	MAR UZ	000					

			For State Registrar	State of Maryla		artment of H			giene Reg. NG 0 0 5	06700
			Decedent's Name (First, Middle, Last	")				2. Date of Dea	ith	3. Time of Death
	Physici /Medio		Alvesta	H	Mye	rs	I	Month Februar	y 17 , 200	3:20 PM M
	Examin		4a. Facility Name (If not institution, give			,	r Location of Death		4c. County of De	
			Holy Cross Hospi		land himbolaul	Silver S		O Data of Birth	Montgom	
	Funeral Director		3,7 20 1232	7. Age (in yrs	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day June 6,	1924 Vi	irthplace (State or Foreign Country) rginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	ţo	MD Prince G	George's I	Distric	t Heights	3			1 ☐ Yes 2 ☐ No
	or 28a	Director	10e. Street and Number			10f. Zip Code	***	1	10g. Citizen of What (Country?
	23a c	aiD	2020 Brooks Drive	Apt. 136		20747	7		USA	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23s or 28s-f show or other treumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes W No If Yes, Give Year or Dates:		Was Decedent of Hill Yes, specify Cubin	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)		
2-0	72 ho	Completed by	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	pation during most of working	a	16b. Kind of Busines	s/Industry
2	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		II C D	tal Service
2	filed within Hygiene. other then "	Co	10 17. Father's Name (First, Middle, Last)		PI	essman	18. Mother's Name	(First, Middle		tal Service
lan(d be antal	To Be	Lennie Harris				Mary Lew		,	
ary	d 2 should be filed within h and Mental Hygiene. 7 is marked other then "treumatic event, the Mag	-	19a. Informant's Name/Relationship (7	ype, Print)		-	and Number or Rural	Route Number	r, City or Town, State	
Σ	and 2 lealth a m 27 li		Amon Myers, Jr						strict He	
ore	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	sition (Name of matory or other plac	·		20c. Location - City of	
Baltimore,	Pa ner ury		`4 □Donation 5 □ Other (Specify) Ha		amily Cen			Ruther Gle	en, VA
Bal	permit. Departn Importe any inju		21. Signatury of Funeral Service Licens	320 400			ss of Facility COOKS Fune:			
		1	23a. Part1. Enter the disease, or comp	olications that caused the dea			11 Port Rong, such as cardiac or		·	Approximate
N.	Physician	(shock or heart failure. List only of immediate Cause (Final	Respiratory	Acido	sis Secor	ndary to CC	חפת		Interval Between Onset and Death
	/Medical		disease of condition resulting in death)	Due to (or as a conse Pneumonia		010 00001	idary co oc	71.0		1
	Examiner		Sequentially list conditions.	b						
	ed sit	Examiner	Sequentially list conditions, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	Due to (or as a consecutive		Failura				
	xecut and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a conse		rallule				
8760,	cate be executed oblysician and the burial-transit	dicai E		d. Dementia		- II- II-				
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnance Other (specify)	у		23d. Date of d Month	elivery Day Year
4	ires that t signed by d be detac	y Ph	Part II. Other significant conditions co	entributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
of Vital Records,	quires an sigr uld be	q pa						1 □ Y	es 2 □ No 3 □ !	Probably 4 Ninknown
900	e law requir has been si je 2 should	piet						24a. Was a		autopsy findings available completion of cause of
Ä		Com						perfor	med? death?	s 2 No
/ita	ysicien: The lar is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital: X		Ott	26. Place of Death			
of	Physicien: rthis certific ral director,	٥.	1 ☐ Yes 2 ♣ No 27. Magner of Death	1 Inpatient 2	☐ ER/Outpatier 28b. Time o				ence 6 Other (Sp ow injury occurred	ecify)
ion	Attending or death. sector: After by the funer	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	rk? Yes 2 □ No	5d. D030/100 11	ow injury occurred	
Division	of or Attendiater death. Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti cify)	reet, factory, office	21	8f. Location (S City or Tow	itreet and Number or i n, State)	Rural Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical C		ysician: To the best of my kinner: On the basis of examinand manner stated.						
	To the comp	D W	29b. Signature and title of certifier	alu C)	29c. Licens	6 2520		29d. Date signed (Moi	
	U		30. Name and address of person who of Maria D'Arbela,	completed cause of death (lite MD 1500 For	e 23a) (Type, rest G1	en Rd. Si	ilver Spri	ng, MD	20910	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	25				
DH	Regist	180	MAR 0 2 21	905 Beau	H. A	harlie	1122 111 12 2			
טח	HANT IT FIGA 1/2	501		₹ 000.036660000	ORIGINA					

			1 - For State Registrar			of Maryla	-	artment of F			Reg. No.	005	06793
	Physici /Medio Examin	cal	Decedent's Name (First, Frank Allen M A. Facility Name (If not instance) Shady Grove	olck itution, giv	e street and nu		21	4b. City, Town, o		2. Date of Dea Month Feb	Day 3-3 4c. Cou	Year 2005 inty of Death	3. Time of Death
	uneral rector		5. Social Security Number 315–56–8300 Usual Residence of Decede	6. S			rs. last birthday, Yrs.		If Under 24 h	Hrs. 8. Date of Birt (Month, Da. 02/01/1	h y, Year)	9. Birthp Cour	lace (State or Foreign
Maryland	a-f show	tor	10a. State 10b. C	ounty	tgamery	10c.	City, Town or L	ocation	Derwoo	xd		1	0d. Inside City Limits No 2 □ No
th with the	23a or 28	Funeral Director	10e. Street and Number 7606 Indian H	ills D	rive			10f. Zip Code	20855		10g. Citizen	of What Coun	itry?
5-00.30 72 hours after death with the Maryland	importent: if item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Evar; it at man be rullified at once.	by	11. Marital Status ↑★ Never Married 2 3 □ Widowed 4 □ Div		Armed F	2∐No [_	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- uerto Rican, etc.)		Race - Americ Black, White, acify: W	
1 2 1 3-1 within 72 h	then "netu re Medicul	Completed			de completed, College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of (working	16b. Kind of	f Business/Inc	dustry
td be filed yental Hygie	ked other	To Be Co	17. Father's Name (First, M Frank Molck, o	, ,	2			Finance V	18. Mother's I	Name (First, Middle,		Serv	riœ
ING Shoul	27 is marl r treumati	Ţ	19a. Informant's Name/Rei Terry Molck /				19b. Maili 7004 (ng Address (Street Edar Knoll	and Number or	Rural Route Numbe	r, City or Tox	wn, State, Zip	Code)
mit. Pages 1 a	nt: if item iry or othe		20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Ott			State	cemetery, cre	osition (Name of matory or other place retery Febru		Date 2005		on - City or To	
pall.	importe any inju once		21. Signature of Funeral Se	rvice Licer)		2	2. Name and Address L. S Charles L. S 1501 Fast R	ss of Facility Stevens I ort Ave I	Funeral Home Altimore MD			
/Me Examined personned	sician and the private transit the private transit tra	dicai Examiner	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	List only	aDue to	(or as a cons	equence of):	æ	g, sun us care	iaco or respiratory an	1001,		Approximate Interval Between Onset and Death
O. DOX O	the attending I hed for use as	hysician/Mec	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 □ No 9 □ Unknown			birth 2 ☐ Fi nant at time o	etal death 3	Ectopic pregnancy Other (specify)				Date of deliver	ry Day Year
of do, F	g	ру Р	Part II. Other significant co	nditions c	ontributing to o	eath but not r	resulting in the u	nderlying cause give	en in Part I.				e cause of death?
n: The law rec	certificate has been si rector, page 2 should	Completed	05 W-								med? 2 No	prior to con death?	osy findings available apletion of cause of
ng Phys	Director: After this certific in by the funeral director,	ation: To Be	2 Accident in	ending vestigation	28a. Date (Mon		ER/Outpatier 28b. Time o	f 28c. Injun Worl	er: 4 🗌 Nursing	Death (Check only or Home 5 Resided Re	ence 6 🗆 C	Other (Specify, curred)
itel or Atter	nerel Directo	Certification:		ould not be etermined	288. Place	of Injury - Al ing, etc. <i>(Spe</i>	t home, farm, str cify)	eet, factory, office	5.0 6	28f. Location (S City or Town	treet and Nui n, State)	mber or Rural	Route Number,
To the Hospitel or Attendi	To the Funeral completely filled	Medicai	one)	lical Exen	niner: On the b	a best of my k asis of exami ner stated.	nowledge, death ination and/or in	vestigation, in my or	pinion, death oc	ace, and due to the courred at the time, d	late and place	e, and due to	the cause(s)
P. Will	2 00	1	29b. Signature and title of c	110	May			29c. License				ned (Month, E	
IL	1		30. Name and address of pe	1440	C			Print) 9707	Rock	77 fish Cents	Jes	18	
F	Sta Registr	_	31. Date filed (Month, Day,		0 2 200	Registrar's S	mature	in Societ	وع				

			1 - For State Registrar	State of Ma	rylan	•		of Health a			giene Reg. No	2000	06791
	Physici	an	1. Decedent's Name (First, Middle, L	ast)		100				2. Date of Dea Month	ith Da	y Year	3. Time of Death
	/Medic Examir	al	Jream Angel Man 4a. Facility Name (If not institution, gr				4b. City, 1	Town, or Location		ebruary	7 25		12:10 A M
н	CAGIIII	Ç.	Southern Maryland	d Hospital	Cent			nton			Pr	ince Ge	orges
Ī	Funeral Director		5. Social Security Number LINK 6.			last birthday)	If Under Months	Year If Under Days Hours	Min.	B. Date of Birth (Month, Day 2/25/20	h /, Year)	9. Bin	thplace (State or Foreign ountry)
	p ,		Usual Residence of Decedent		10- 0	· ·					,05	ITIQI	
	death with the Maryland ms 23s or 28s-f show rmust be millied at	ō	10a. State 10b. County Maryland Prince	Georges		y,TownorLoca per Mar		0					10d. Inside City Limits 12 Yes 2 □ No
	r 28a	Director	10e. Street and Number	o-			10f. Zip				10g. Cit	izen of What Co	ountry?
	ath with	aiD	8835 East Grove	2				20774				USA	
		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	.S. 13. Wa		ent of Hispanic Ori fy Cuban, Mexican	igin? (Spec	ify Yes or No-		14. Race - Ame Black, Whit	
036	o aft	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2√ N If Yes, Give Year or Dates:	lo	- 1	☐ Yes 2	_		isanij story		Specify: B1	
21215-0036	n 72	Completed	15. Decedent's l (Specify onfy highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5	4)	16a. Deceder (Give kii life. DC	nt's Usua ind of wor O NOT use	done during mos	t of working	7	16b. K	ind of Business	Industry
21	e filed within at Hygiene. tother than vent, the Me	Com	Ø	College (1940) 3	*)	NIA					NI	A	
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name (First, Middle,	Maiden	Sumame)	
₹	2 should be and Mental I s markad o raumatic sve	유	James Anthony N			T				ne Rene			
Maryland	s 1 and 2 should be filed withi f Health and Mental Hygiene. item 27 is markad other than othar traumatic svent, the M		19a. Informant's Name/Relationship Jacqueline Marti					(Street and Number Grove; [
	s 1 an if Heal item 2 other		20a. Method of Disposition	III IIICIICI	20b. P	lace of Disposit	tion (Nam	e of	Da			ocation - City or	
ē	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		For	emetery, crema t Linco	itory or oti 1n Ci	rematory	3/2/2	2005		ntwood,	
Baltimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Lice					Address of Facilit				Funera	
_	0 □ = # O		23a. Part 1. Enter the disease, or co	obert				Ladensbur				ood MD	20722 Approximate
8760,	Physician and /Medical Examiner he prival-transit	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c Due to (or as a d d.	a conseq	uence of):	209	ytu uk. 5.	ertai	tin			Interval Between Onset and Death
P.O. Box 68	death certifics e attending pt ed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of the companies o	2 🗌 Feta	Ideath 3 E	ctopic pre					23d. Date of del Month	ivery Day Year
	8 5 0	by	Part II. Dther significant conditions	contributing to death bu	t not res	ulting in the und	erlying ca	use given in Part I.					the cause of death?
Š	w require been sit should b	etec								-			
Division of Vital Records,	The la ate has page 2	Completed								24a. Was a autops perform	sy med?	prior to death?	topsy findings available completion of cause of 2□ No
Vita	Physician: The this certificate ral director, pages	Be	25. Was case referred to medical examiner?	Heeritel.				7	of Death (Check only or	10)		
of	Phys this aldi	- T	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatier 28a. Date of Injur		ER/Outpatient 28b. Time of	3 DO/					6 □Other (Spec	cify)
ion	ttending I death. ctor: After y the funer	ation	1 Natural 5 Pending 2 Accident investigation	on (Month, Day	Year)	Injury	м 20	c. Injury at Work? 1 ☐ Yes 2 ☐ I		d. Describe h	ow mjui	y occurred	
Divis	or A after Dire	Certification:	3 Suicide 6 Could not determine		ry - At ho . (Specif	ome, farm, stree y)	t, factory,	office	28	f. Location (Si City or Town	treet an n, State	nd Number or Ru)	ural Route Number,
	e Hospital 124 hours e Funeral letely filled	edical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the best of miner: On the basis of and manner sta	examina	wledge, death o	occurred a stigation,	t the time, date an in my opinion, dea	d place, an th occurred	d due to the c at the time, d	ause(s)	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1× 27)	all	29c.	License number		2	9d. Dai	te signed (Mont)	h, Day, Year)
)			HINA	aum				D34302			1	- 28	05
1	1		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, Pr	rint)	- 1-0					
1			31. Date filed (Month, Day, Year)	32. Registra	T's Sinn	na	103	Vite (
	Sta Registr		MAR 02	2005 32. Hediska			parte.	,					

amend item#24a,26 per#9, C841, 3/2/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 27 **Physician** 2005 01:29 STANLEY McKENNA /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 31,1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 120 M 2 □ F 215-40-4890 75 Yrs Oct. England Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow iral", or items 23a or 28a-f ehov Exercitive must be notified at 1 Yes 2 No Maryland Anne Arundel Directo Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 243 Severn Road 21108 U.S.A. Funerai permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced "natural" Department of Health and Mental Hygiene. Importent: If Item 27 Ie marked other than "natueny injury or other traumatic event, If a Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Nabisco & Kraft Elementary/Secondary (0-12) College (1-4or 5+) Food Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James McKenna ျှ Jane Molyneaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Jones (Sister) 5212 Disney Avenue, Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cem. 03-03-05 Batimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Polyniak Funeral Home P.A. Patapsco Avenue, Baltimore, 21225 Marvland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-t P.O. Box 68760, physician Physician/Medical as the the attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ached 9 Unknown 9 Unknown ፩ det signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topeoco use contribute to the cause of death? Division of Vital Records, Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3□ DOA 6 DOther Com (his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) MAR 0 2

2005

			1 - For State Registrar	State of Marylar	nd / Depa			lental Hygi	•	
	Physici /Medi		1. Decedent's Name (First, Middle, Last, MA2 Y MARG	ARET	MANI			2. Date of Death Month TEBJARY	Day Yes 24 2005	1.4
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give JOHNS Holkins BAY July 5. Social Security Number 216-20-7729	N Medical Cent			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 1,	4c. County of D N/A 1927 N	eath Birthplace (State or Foreign Country] Iaryland
	e Maryland Se-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. Cit	ty, Town or Lo		Baltimore			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with the 23e or 21	ral Dire	10e. Street and Number 109 F	Cast West St.		10f. Zip Code	21230	10	g. Citizen of What USA	Country?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23e or 28e-f show or other treumatic event, the Middical Example must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🏧 Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	mencan Indian, Thite, etc. White
21215-0036	d within 72 he giene. Ir then "natu Ire Medical	ompletec	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 10		(Give	dent's Usual Occup kind of work done DO NOT use retire Salesper	during most of worki d)	ng	6b. Kind of Busine Tommy Tu	
Maryland	should be filed and Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)	Edward Thu	ıman		18. Mother's Name Mary	(First, Middle, M Schill		
	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (Ty William Michael Ma	annion, Jr. (S	SON) 7	' Arrowsh	and Number or Rura	altimore	City or Town, State, Md. 2	a, <i>Zip Cod</i> e) 1222
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other then emy injury or other treumatic event, Ins.M. <u>ODGe.</u>		20a. Method of Disposition 1 译Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	lemoval from State Ho	Ty Cro	sition (Name of natory or other pla SS Cemete	ery 2/28	3/05 I		e, Maryland
Ball	permit. Depart Import eny inj		21. Signature of Funeral Service License	New Periods	1	CCully Po	olyniak Fu rt Ave., I	neral Ho Baltimore	ome, P.A. e, Md. 2	1230
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	tis	er the mode of dyir	ng, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	ate be executed thysician and the burial-transit	ical Examiner	Sequentially list conditions, and a sequentially list conditions, and a sequential seque	Due to (or as a conseq						
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	w requires that the de been signed by the a should be detached to	by	Part II. Other significant conditions con DAETERRUMA, CONGRE				en in Part I. ENM TAILUIC			to the cause of death?
of Vital Records,		Completed	Diasetes Mellitus	AtriAL FIBRILAT	ion.			24a. Was an autopsy performe 1 ☐ Yes 2	prior t ed? death	
25. Was case referred to medical examiner? 1 Yes 2 No										pecify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, stre			28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospitel or, within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dir	edical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	To with	Σ	29b. Signature and title of certifier	1		29c. Licens		1_ 1	d. Date signed (Mo	
Ç		Ì	30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, I	Print)	IMONE M		ovMy, 24	, 2005
:	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		South !			<u> </u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 05 PM WADE MOSES 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Buttmore (H Maryland OHa N/A neral 7. Age In yrs. last birthday) 5. Social Security Number B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊋M 2□F Months Days Yrs. Director 214-68-4705 47 06/09/1957 MARYLAND Usual Residence of Decedent perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD N/A XXYes 2□No **Funeral Director** BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5708 WINTER AVENUE USA - 14. Race - American Indian, Black, White, etc. 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2☐ Married 1 ☐ Yes 2 X No Specify: SpecBLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) FALLS ROAD ANIMAL College (1-4or 5+) DOMESTIC WORK 10TH HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY MOSES 2 FLORENCE DILVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10841 FARYS MILL RD, DOROTHY COOK / COUSIN GLOUCESTER, VA 23061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ZION HILL CEM. * 4 □ Donation 5 □ Other (Specify) 3/5/05 GLOUCESTER, VA 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 LIBERTY **HGHTS** Approximate Interval Between Onset and Death of the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final dise of or condition resulting in death) Pnysician onsequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner -transit The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No this certificate 1 ☐ Yes 2 10 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) title of certifier

State Registrar

te 31. Date filed (Month, Day, Year) ar MAR 0 2 2005

M.D. OD M()
30 Registrar's Signature

raver, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

No popular

			1 - For State Registrar		Maryland	/ Depa		Health	and M	•	/giene2	05	06798
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ранишог	permit. Pages Department of Important: if it any injury or o		X Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Li	cify)	ate MD	VETE	CRAN CE CRAN CE ON FORE Name and Ad	CAT	03/0	09/05 ELL F	OWINGS UNERAL	MIL	J.S. MD
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	40	1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month	Day	Year 3. Time of Death
/Medic	al.		EE MON				FEBRUA	RY 26, 2	005 11:03P.
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		JOHNS HOPKINS HOST 5. Social Security Number 6. S.		Age (In yrs. last birthda	BALTIM BALTIM		4 Hrs 9 Date of Bi	ath.	n/a
Funeral Director			M 2□F	27 Yrs.	Months Days			1,1978	9. Birthplace (State or Fore Country) Maryland
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ehow Et al		10a. State 10b. County		10c. City, Town or					10d. Inside City Lim
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or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Robe Fecility Name (If not institution, give street end number)

Yrs.

7. Age (In yrs. last birthday)

75

Physician /Medical Examiner **Funeral** Director the Marylenc 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at Director Peges 1 and 2 should be filed within 72 hours after death with Baltimore, Maryland 21215-0020 Journal of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumetric pince.

311 Hoods Mill Road 21797 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 € No If Yes, Give X Year or Dates: 1 □ Yes 2 ŪWo Specify: Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor 17. Father's Neme (First, Middle, Last) Be Robert H. Mercer, Jr. 19a. Informant's Neme/Relationship (Type, Print) Mrs. May Elizabeth Mercer (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 3/2/05 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sykesville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner or Attending Physician: The law requiras thet tha daath certificate ba axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ Completed page 2 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Certification: To 1 Yes 2 No 3□ DOA 2 ER/Outpatient this 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No I Director: A investigation 6 ☐ Could not be etermined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated completaly 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and the of confile 29d. Date signed (Month, Day, Year) D3484

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

MD

Jan

William

31. Date filed (Month, Day, Year)

1645

32. Registrer's Signature

100

6. Sex

Carroll

1√2 M 2□ F

5. Social Security Number

215-34-5826

10e. Street end Number

10a. State

MD

Usuel Residence of Decedent

10b. County

4c. County of Death If Under 1 Year 9. Birthplace (State or Foreign Days MD 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Woodbine 10f. Zip Code 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Construction 18. Mother's Name (First, Middle, Maiden Sumame) Eunice Marian Cass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Hoods Mill Road Woodbine, MD 21797 20c. Location - City or Town, State Marriottsville, MD HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) MD 21784 (410)-795-1400 Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2005

DHMH 16 Rev 6/95

State Registrar Liber

Road

Eldersbur

			For State Registrar	State of Maryla		artment of rtificate of			ene g. No 2005	06801
	Physici	an	1. Decedent's Name (First, Middle, Last)	N 72 1				2. Date of Death Month	Dav Year	3. Time of Death
	/Medic	al	Everett 4a. Facility Name (If not institution, give s	McFarland treet and number)		4b. City, Town,	or Location of De	Februar	y 25, 2005 4c. County of Death	6:00am [™]
	Examin	er	4600 Sykesville Ro	and the same of th		, ,	sburg			roll
	Funeral Director		110 01 22/0 11	M 2□F 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Yea Months Days		Ars. 8 Date of Birth (Month, Day, March 1	9. Birth 1, 1919 K	place (State or Foreign intry) entucky
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Carrol1	10c.	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	ath wi	ral	4600 Sykesville Ro				21048		USA	
326	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental tyglene. Department of Health and Mental tyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show appringnt or other traumatic event, the Medical Evaluation returned to notified all once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🌠 No		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
212-00	hin 72 hou s. an "nature Medical E	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give life.	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of ed)	working 1	6b. Kind of Business/I	ndustry
21	ygiene ygiene yertha t, the		12		Rai	11road Wo			Railroad	
Baltimore, Maryland 21215-0036	ould be fit Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Thomas H. Mc				Sar	Name (First, Middle, Mah S. John)	son	
<u>Mar</u>	d 2 sh th and 7 is m fraum		19a. Informant's Name/Relationship (Type Mrs. Helen L. McFa		1.			r Rural Route Number, Lot#124 Fil		
<u>6</u>	s 1 and f Heall itsm 2 other		20a. Method of Disposition	201	o. Place of Dispo	osition (Name of matory or other pl	1		Oc. Location - City or T	
<u>E</u>	Pege nent o ant: If ury or		1 ☐ Burial 2 【☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	y Cremat		26/2005	Sykesville	, MD
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service License	Haight	1 1 2	AIGHT FU Sykesvill	MERAL H Le, MD 2	OME & CHAP 1784 (410)	EL PA (Bo: -795-1400	x 195)
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	reim		^	diac or respiratory arre	st,	Approximate Interval Between Onset and Death Vlavs
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of).					
8760,	cate be executed oblysicien and the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):				4	
.O. Box 6	the death certific y the attending p tched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3[□Ectopic pregnan □ Other (specify)	су		23d. Date of deli-	very Day Year
О.	es De pe	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the c	ınderiying cause ç	pven in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to	
of Vital Records,	The law ate has b page 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			ther	Death (Check only one)	
	fing After fune	tion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatie 28b. Time of Injury	of 28c. In	4 Nursin	28d. escribe ho	nce 6 ⊡Other (Spec w injury occurred	ify)
Division	tea for tor	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, st ecify)			28f. Location (Str City or Town	eet and Number or Rui State)	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea nination and/or ir	th occurred at the nvestigation, in my	time, date and p opinion, death o	lace, and due to the ca occurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
34 S	To the	W	29b. Signature and title of certified	turs		29c. Lice	nse number		d. Date signed (Month	, ,
	5		30. Name and address of person who co Stwars. Net, v	mpleted cause of death (Item 23a) (Type	Print)	BIVE	, FIDE	usburg 1	MN 31784
	St: Regist	ate	31. Date filed (Month, Day, Year)	32. Regultrar's Si	gnature	Anna			ð	

		State Alleria Items	State of M 23a per Dr., G	291,05/U	Z/Certifi	cate of	Death	1			2005	0.680
Physici	an	Decedent's Name (First, Middle, I	_ast)						2. Date of De Month	Da	y Year	3. Time of Death
/Medi			OTTING					112	02	27		19:498
Examir	ner	4a. Fecility Name (If not institution, g		ULI	1 -5	City, Town, o					. County of Dea	
		JOHNS HOPKINS 5. Social Security Number 6	Sex 7. AS	ge (In yrs. last I		Jnder 1 Year		r 24 Hrs.	8. Date of Bi		ALTI M	thplace (State or Forei
Funeral Director		212-32-9587	1 X M 2□ F			nths Days	Hours	Min.	8. Date of Bi (Month, Di	ay, Year)		ountry)
		Usual Residence of Decedent			1					, , ,	/ FIC	
nylan how		10a. State 10b. County			own or Location	n						10d. Inside City Lim
e Ma	cto	Md. Balti	more	Dun	dalk							1 ☐ Yes 2 💢 I
th with th	Funeral Director	7107 Dunshire W	ay Apt.A4		1	of. Zip Code 212	22			10g. Ci	tizen of What Co SA	ountry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantinal must be notified at	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	(No		Decedent of H s, specify Cub res 2 No	lispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W	
within 72 ho ene. then "natur the Medical I	Completed	15. Decedent's (Specify only highest the Elementary/Secondary (0-12)		54)	life. DO l	of work done IOT use retire	durina mos	st of worki	ing		ind of Business	/Industry
filed withi Hygiene. ther then	Ю	8 yrs.			Truck	Driver				1	sphalt	
2 should be filed and Mental Hygie is marked other aumatic event, II	To Be (17. Father's Name (First, Middle, La Grover Nottin						ner's Name Biel	e (First, Middle el	e, Maider	Surname)	
id 2 shou lth and M 27 is mar traumat		19a. Informant's Name/Relationship Patricia Notti			•						or Town, State, Md. 21	
Pages 1 and 9 ent of Health nt: If item 27 ry or other tra		20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State	20b. Place ceme	of Disposition itery, cremato ed Hear	n (Name of ry or other pla	ce) N	March	Date	20c. L	ocation - City or ndalk	
permit. Pages: Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lie			Conn 7110	me and Addre	ss of Facil unera rs po	Y Hor	ne Of E Rd. 212	unda 222	ılk	
Physician /Medical		23a. Par11 Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	a. CAR	ed the death, D line. LiAC s a consequence	ARR	•	ng, such as	s cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
aght certificate be executed by a standing physician and for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as c. Sepsis	PIRAT s a consequence s a consequence	ce of):	ARRE	ST					
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uires that the de signed by the a id be detached f	by	Part II. Other significent condition	s contributing to death	but not resulting	g in the under	ying cause gr	ven in Part	I.		tobacco Yes 2		o the cause of death?
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Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	I to asital:					e of Deat	h (Check only	оле)	-	
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To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Aedicai	(Check only 2 Medicel Ex	Physicien: To the best ceminer: On the basis and manner s	of examination	and/or invest	gation, in my	opinion, de	ath occur	red at the time	, date an	d place, and du	e to the cause(s)
To To	Σ	29b. Signature and title of certifier				29c. Licens	se number			- /	ate signed (Mon	
		30. Name and address of person w	MMM, M	death (Item 23)	a) (Type, Prin	RES	- OX	00		2/	26/05	-
())		30. Name and address of Deison w										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30 am Ma 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randalls Town 101 aus Xma ď If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 7, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 NC **Funeral** Months Days Hours Min 1 □ M 2 1 F 1908 219-42-6989 96 Yrs. Director Usual Residence of Decedent 10a, State 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 5114 Old Court Road 21133 or itema 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give X 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced Year or Dates "naturai", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Practical Nurse Health Care f Health and Mental Hygi item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be Robert Lee Rogers Flora Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nan A. Neil (Daughter) 6614 Monroe Avenue, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges
Department of H
Important: if its
any injury or of
once. N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Fairmount Cemetery 3/3/2005 Libertytown, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that oaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition **Physician** ue a /Medical resulting in death) Due to (or as a consequence of): Examiner 11 SV enal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and the burial-transit MONIC anomio Due to (or as a consequence of): Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ę, 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been si Be Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an has autopsy performed? page this certificete

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospitei

After

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filled

death.

within 24 hours after deat To the Funeral Diractor:

To the

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 NO 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Ceath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title # 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 HeV 1/2001

30. Name and addr

who completed cause of death (Item 23a) (Type, Print)

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			1 - For State Registrar		State	of Maryla	and / Dep <i>Ce</i>	artmer rtificat				ental H	ygiene Reg. No	01	105	0000
	Physic		Decedent's Name (First, Midde									2. Date of D Month	Day		Year	3. Time of Death
	/Medi Examir		Paul E. Pits 4a. Facility Name (If not institution	enbe on, give st	rger reet and ni	ımber)		4b. City,	Town, or	Location of		Februa			005 of Death	11:30P [™]
			Larkin And	Chas	e Nur	sing H	ome	Bow	ie				P	rinc	e Geo	orge
	Funeral		5. Social Security Number	6. Sex	M 2□F		s. last birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B Month, D 2/16/1	irth ay, Year)		9. Birthp	lace (State or Foreign
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	Marie Strate	to	Maryland Princ	e Ge	orge		Bladens	burg								1 X Yes 2 ☐ No
	or 28	lrec	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of W	Vhat Coun	ntry?
	ath w	rai	4323 54th Stre					20	710				U.S	. A .		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Fheath and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Evantral must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried	Armed F	2 □ No ive	U.S. 13.	Was Dece If Yes, spe 1 \(\text{Yes} \)		spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto f	cify Yes or N Rican, etc.)	0-		e - Americ k, White, WHit	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural," any injury or other traumatic event, the Medical Evanone.	ted	15. Decede	nt's Educa	ation		16a. Dece	dent's Usu	ai Occupa	ation			16b. Ki	ind of Bu	wn_t siness/Ind	
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Maryland	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relation Jeffery W. Pits		-	Son						Route Numi		r Town, .	State, Zip	Code)
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	Physician /Medical		23a. Part 1 Enter the disease, o shot, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	mplicationly one	Meta	each line.	Diseas					respiratory i	arrest,			Approximate Interval Between Onset and Death
,8760,	requires that the death certificate be executed seen signed by the attending physician and includ be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, learning to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c. d.		(or as a conse										
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	To the Hospital or within 24 hours after To the Funeral Dii completely filled in	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physic Examine	r: On the b	e best of my ki pasis of examinated.	nowledge, deat nation and/or in	h occurred vestigation	at the timi	e, date and inion, deat	d place, ar	nd due to the d at the time,	cause(s) date and	and mar place, a	nner as sta nd due to	ated. the cause(s)
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•	01		1 DAY	4)	mi		D456	560			02/2	4/20	005	
•	5		30. Name and address of person	who com	pleted cau	se of death (Ite	em 23a) (Type.	Print)						-1/4		
1	J		DPinder				allant	Fox L	n. #:	124 B	owie,	, MD 2	0715			
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D22, 2005 Physician February Marguerite J. Pettigrew 11:40A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 ct. 21, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 252-16-2898 85 **Director** Augusta, GA Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at Director Montgomery Takoma Park th€KYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7527 Carroll Ave 20912 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2√No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify. **Black** 3 Widowed 4 □ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiem 27 is marked out Thomas Joesy Effie Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane McCants/ Cousin 2357 North Forest Dr. Marietta, GA 30062 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Properties 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any Injury or once. ō Ft. Lincoln Cemetery 2/26/2005 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Fungral Service Liesnsee 3401 Bladensburg Road Brentwood, MD 20722 romosi Mesharol 23a. Part 1. Enter the disasse, or complications that caused the death. Do not enter the mode of tyring, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (us as a consequence oi). To the Hospitel or Attending Physicien: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic preonancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 autopsy performed? page this certificate director Be case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hosbital: 2 1 Yes 2 10 1 Inpatient 2 EN Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D. 7610 Carroll Ave Takoma Park, MD20912 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 26, 2005 \mathbf{P}^{M} 8:30 February Pascha11 J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Fairland Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Jan. 4, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1929 Henderson, NC 1 M 2 □ F 76 Yrs. 579-52-8408 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinarizative notified at Greenbelt 1 ¥Yes 2 No Prince George's MD Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number s should be filed within 72 hours after death with the and Mental Hygiene. 20770-3304 United States 7708 Lakecrest Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Nes 2 No 1948— If Yes, Give Year or Dates: 1957 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ᡮ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Educational consultant 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Sallie Henderson William Paschall, Sr. ပ္ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7708 Lakecrest Drive Greenbelt, MD 20770-3304 Carlyn Paschall/ Daughter Health tem 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 3/5/2005 Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Lice ee Brentwood, MD 20722 3401 Bladensburg Rd. uhard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Human Immunodeficiency Virus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hepatitis B leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alzheimer's Disease Compl autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 💢 No Diabetes Mellitus Type II 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Cther: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 😾 No ္ရ this 28c. Injury at Work? funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Hospital or Attending Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 | Homicide 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 3/1/2005 D 52261 ress of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest

Alexan St. Sperti

32. Registrar's Signature

Alan R. Segal, M.D.

31. Date filed (Month, Day, Year)

Glenn Rd,

Silver Spring MD

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

Phy: /Mc

Division of Vital Records, P.O. Box 68760,

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Funeral Director		5. Social Security N 220-21-2	482	6. Sex 1 ☑ M 2 ☐ F	_	(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours A	Ain. (Month, I	Dav. Year)	Con	place (State or Foreign intry) hington DC
and w		Usual Residence o 10a. State	f Decedent 10b. County	,		10c. City	, Town or Lo	cation					10d. Inside City Limits
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w require been sign should b										_ 1	Yes 2 X No	3 Prol	oably 4 DUnknown
The law cate has b page 2 sh	Completed										opsy	prior to co	ppsy findings available impletion of cause of
n: Th ficate or, pag	e Col	25 18/22 2222 19/22	rod to modica							1 Yes		death?	2 □ No
ysicien: nis certific director,	To Be	25. Was case refer examiner? 1 XYes 2		Hospital:] Inpatient	1 2 🗆 E		3 DOA Othe		Death <i>(Check only</i>		Other (Specia	AT SCENE
ding Ph h. After thi funeral	L iuc	27. Manner of Deat	h 5 🗌 Pendir	28a. Date			28b. Time of Injury	28c. Injury Work	/ at	20d Describe	how injury oc	arrea d	
ttandii death. tor: A the fu	icatle	2 Accident	investi	gation 2-Z	8-05		3:14		Yes 2 No	Collids q	wal on	william W	wfor vehicle
or Attanate deat Diractor:	Certification;	4 Homicide	meteb	nined 286. Plac build	ding, etc.	(Specify)	.0	eet, factory, office		City or To	own, State) K	emp Hi	
To the Hospitel or Attanding Physicien: The law requires that the death certificate within 24 hours after death. To tha Funarial Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier (Check only one)	1☐ Certifyir 2 Medical	ng Physician: To th Examiner: On the l	e best of basis of e	examination	rledge, death	occurred at the tim	ne, date and pla pinion, death of	ace, and due to the	e cause(s) and	manner as s ce, and due to	tated
To the within To the comple	Me	29b. Signature and	2	r.				29c. License	number		29d. Date sig	ned (Month,	Day, Year)
1		> h	ing hi	, m.D				OCI	ME		MARCI	f 1, 20	005
		30. Name and addr		who completed cau	use of dea	ath (Item	23а) (Туре, І	^{Print)} 111 Per	nn Stre	et Balt	imore,	Maryla	and 21201

State Registrar

LING LI,
31. Date filed (Month, Day, Year) MAR 0 2 2005

32. Registrar's Signature

Frederick Peters 05-1525 AKG **1**-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

525			1 - State Amend Item 40	State of Mar &Unpend It	yland/Depa em 23a&27	artment of H	lealth and 841 3-24 Beath	Mental Hy -05 tas	rgiene Reg. No.⊃ ∩ (^{rol} s , circle
	Physici		1. Decedent's Name (First, Middle, La Frederick W. Pet	st)				2. Date of De Month Februar	Day	Year 05 9:30 A M
	/Medio Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Dea		4c. County o	
	ZAGITIII	-	St. Agnes Hospita	1.		Baltimo	ore		N	I/A
	Funeral Director		5. Social Security Number 6. S 220-56-0580	ex 7. Age ☐XM 2☐ F	(In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year) , 1957	9. Birthplace (State or Foreign Country) Maryland
<i>p</i>	pug 🗼		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryla r sho	ō		imore		Arbutus				1 ☐ Yes 2X No
	the A	rect	10e. Street and Number	Linore		10f. Zip Code			10g. Citizen of W	hat Country?
	death with the Maryland ms 23a or 28a-f show Frivist ke ricdiffed at	D	1309 Stevens Ave	nue		21	227		United S	States
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinat mast ke ricitized at ance.	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Micropole	12. Was Decedent Ev Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		- American Indian, k, White, etc. White
21215-0036	thour	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	siness/Industry
215	nin 72 in "ing	piet	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most of wo i)	orking	Mid Atla	antic
212	giene giene er the	mo:	12	3010g5 (1 401 51		Maintenan				nt Rental
pu	al Hy al Hy d other	Be (17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle	e, Maiden Sumame)
Maryland	ould b Ment arke	P	Theodore Peters					a Estep		
lar	2 sh and 1s m		19a. Informant's Name/Relationship (ng Address (Street				
	1 and 4ealth em 27 ther t		Theodore Peters	Jr. Brothe	20b. Place of Dispo	Stevens		Arbutus		27 City or Town, State
و	ages nt of h		Burial 2 Cremation 3		Meadowri	datee or other place		0005		•
Baltimore,	artmer artmer ortant injury	1	1. Sign was of Funeral Service Level	y)	Memoria	L Park 2. Name and Addre		-2005	Elkrid	
Ba	permi Depar Impo any ir	(Ou Waling !	ROLLIN		328 Sulph				
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. Atherosc1	erotic Ca				arrest,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	consequence of):					
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	consequence of):					
.O. Box 68	The law requires that the death certifics to has been signed by the attending blings 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mon	e of delivery th Day Year
Δ.	w requires that been signed by should be deta	þ	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		tobacco use contri Yes 2 □ No	bute to the cause of death? 3 Probably 4 Unknown
Vital Records,	a cr	Completed						24a. Was auto perf 1 Ves	opsy promed? de	Vere autopsy findings available rior to completion of cause of eath? Yes 2 \(\subseteq \text{No} \)
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04	or	ath (Check only		
of	di S	P	1 XYes 2 No	Hospital: 1 Inpatien			4 140131119		idence 6 Othe	
n C	fe fe fe fe fe fe fe fe fe fe fe fe fe f	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occurre	90
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined		y - At home, farm, st (Specify)		700 2 2 100	28f. Location City or To	(Street and Number own, State)	or or Rural Route Number,
	he Hospin n 24 hour he Funera	edicai (nysician: To the best of miner: On the basis of e and manner stat	examination and/or in					
	To the To the comp	Ň	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	OC Print)	ME		Maı	rch 1, 2005
			LING LI	mid		111 Pe	nn Stree	t Balt:	imore, Ma	ryland 21201
	St. Regist	ate	31. Date filed (Month, Day, Year)	32, Recentral	's Signature	hicke				

	1 - For State of Marylar Begistrar Amend Items 23a,29d per Dr. 1. Decedent's Name (First, Middle, Last)	nd / Department of He ,0841 /03/02/03 th Certificate of L		10g. 110,
Physician		D to to -	2. Date of Dea Month	Day Year
/Medical Examiner	Margaret T. 4a. Facility Name (If not institution, give street and number)	Perretta 4b. City, Town, or I	Februa	ary 8 2005 4:25 a M
LAGITIFICI	1321 Chapelview Drive	Odent		Anne Arundel
uneral	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Birtl Hours Min. (Month, Day	
ctor	107-20-4684	Yrs.	Apr. 16	,1927 New York
Be Completed by Funeral Director		ity, Town or Location		10d. Inside City Limits
to	MD Anne Arundel O	denton		1 ☐ Yes 2√ No
Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
ral	1321 Chapelview Drive	2111	.3	USA
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupat (Give kind of work done du	ion	16b. Kind of Business/Industry
Jdu	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
	12	Secretary		Army/Airforce Exchange
Be	17. Father's Name (First, Middle, Last) George Schoen		8. Mother's Name (First, Middle,	
2	19a. Informant's Name/Relationship (Type, Print)		Catherine Tigln d Number or Rural Route Number	
	Nancy Connell (Daughter)		Court, Crofton	
	20a. Method of Disposition 20b. F	Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1	I - Dunar E Monation o Chromova nom State	tro Crematory	1	Baltimore, MD
SIICE	21. Signature of Funeral Served Intensee	22. Name and Address Hardesty 12 Ridgel	of Facility Funeral Home, P y Avenue, Annapo	. A .
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen			
hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Il death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
by P	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given	in Part I. 23e. Did tob	pacco use contribute to the cause of death?
Completed			24a. Was ar autops perforn 1 Yes 2	y prior to completion of cause of
Be	25. Was case referred to medical examiner?	Othor	6. Place of Death (Check only one	8)
atlon; To	1 Yes 2 No rouspital: 1 Inpatient 2 Inpati	ER/Outpatient 3 DOA Other: 28b. Time of Injury M 28c. Injury a Work? M 1 Ye		nce 6 □Other (<i>Specify</i>) w injury occurred
Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my kno 2 Medical Exeminer: On the basis of examina and magner stated.	wledge, death occurred at the time, tion and/or investigation, in my opin	date and place, and due to the ca ion, death occurred at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
7	29b. Signature and title of certifier Reve har see	ND DOO	61343 2s	d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item Rinku Mukherjee, MD Kimbr	1 23a) (Type, Print) Cough Med. Center	r, Ft. Meade. MT	20755
State gistrar	31. Date filed (Month, Day, Year) MAR 0 2 2005 Registrar's Sign	pire Gozele		

ian	A. Rose	5	1 - For Unpend Item Registrar	23a,27,28	aryland/De a-f per my	epartment of 1 e G84 I 3-3 Certificate of	Health and N -05 tas Death	nental Hyg	iene 2005	06810
			Negistrar Decedent's Name (First, Middle,			ortineate or		2. Date of Deat		3. Time of Death
	Physici		Brian A. Rose					February	7 11, 2005	9:43 A M
	/Medi Examir		4a. Fecility Name (If not institution,	give street and number))	4b. City, Town, o	or Location of Death		4c. County of Death	
			1431 Myrtle Ave	ทเาค		Baltimor	re.		NA	
3	Funeral		5. Social Security Number		ge (In yrs. last birtho	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Birth	place (State or Foreign
2	Director		217-66-5533 Usual Residence of Decedent	TESM ZUF	45 Yr	S.		06-25-195	9 Mary I	ańd
* 0	land		10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
	Mary fied	ţŏ	MD I	VA.	B	altimore				1 XYes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Cou	intry?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exam hat must be notified at	a D	1331 Essex Road				21207		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Amed Forces	Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
36	s afte	by Fu	1 X Never Married 2 Marrie	If Yes, Give	.No	1 ☐ Yes 2 🛣 No	Specify:	,	Canait	
Ö	hour tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	162 D	ecedent's Usual Occup	action		Bla	
5	in 72 n"na	Completed	(Specify onfy highest	grade completed)	(C	Give kind of work done fe. DO NOT use retire	during most of work d)	ing	16b. Kind of Business/Ir	ndustry
212	I with	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Driver			Trucking	
Þ	a filed of the vent,	BeC	17. Father's Name (First, Middle, La	ast)			18. Mother's Nam	e (First, Middle, A	faiden Sumame)	
<u>la</u>	uld by Menta Irked Itic e	To	Theodore Rose	Sr.			Marie Whi	.te		
Baltimore, Maryland 21215-0036	2 sho and I Is me	0. 3	19a. Informant's Name/Relationshi	p (Type, Print)	19b. N	Mailing Address (Street	and Number or Rur	al Route Number,	City or Town, State, Zi	p Code)
≥ ∞	and lealth m 27 her tr		Evie White/ Aunt			6 Mayfair Roa				
ore	gas 1 it of H its		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	3 □Removal from State	cemetery,	isposition (Name of crematory or other place	ce)		20c. Location - City or T	
ŧ.	t. Pa ntmen ntant: njury		'4 □ Donation 5 □ Other (Spe		Metro Cre		03-02-	-05	Catonsville,	MD
Bal	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examble must be notified at once.		21. Signature of Funeral Service Li	Icensee	-	22. Name and Addre		I. Gilmor S	St./Baltimore,	MD 21217
	_		23a. Part 1. Enter the disease, or c	complications that cause	d the death. Do not					Approximate
	â		shock, or heart failure. List of	nly one cause on each I	ine.	,	3,	,	,	Interval Between
	Physician			C	3 TY	T	. 0 1		W 1 1	Onset and Death
-	/Medical		disease or condition resulting in death)	_ M			ion Compl	icated By	y Multiple	
			resulting in death)	Due to (or as	nd Heroin s a consequence of)		ion Compl:	icated By	y Multiple_	
	/Medical Examiner	ner	resulting in death) Sequentially list conditions,	Due to (or as		:	ion Compl:	icated By	y Multiple	
	/Medical Examiner	aminer	Sequentially list conditions, any, teacing to increase cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of)		ion Compl:	icated By	y Multiple	
30,	/Medical Examiner	l Examiner	Sequentially list conditions, any, leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)		ion Compl:	icated B	y Multiple	
8760,	/Medical Examiner sician and parial-transit	cal	Sequentially list conditions, any, teacing to increase cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of)		ion Compl:	icated By	y Multiple	
687	/Medical Examiner sician and parial-transit	cal	resulting in death) Sequentially list conditions, any leading to in resulting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	s a consequence of)		ion Compl:	icated By		Injuries
687	certificate be executed was ding physician and case as the burial-transit	cal	Sequentially list conditions, flany, leading to inchediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as b. Due to (or as d. 23c. If yes, outcome 1 Live birth	a consequence of) a consequence of) a consequence of) of pregnancy 2 ☐ Fetal death	: : : 3 □Ectopic pregnancy		icated B	y Multiple 23d. Date of delive Month	Injuries
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P.O. Box 687	certificate be executed was ding physician and case as the burial-transit	by Physician/Medical	Sequentially list conditions, any, teaching to inchesiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as b. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	s a consequence of) s a consequence of) s a consequence of) s of pregnancy 2	3 □Ectopic pregnanc, 5 □ Other (specify) □	y	23e. Did tob	23d. Date of delive Month	Injuries ery Day Year
P.O. Box 687	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, any, teaching to inchesiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as b. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	s a consequence of) s a consequence of) s a consequence of) s of pregnancy 2	3 □Ectopic pregnanc, 5 □ Other (specify) □	y	23e. Did tob 1	23d. Date of delive Month acco use contribute to the second of the sec	Injuries Pery Day Year Ithe cause of death? bably 4 □Unknown Dosy findings available
P.O. Box 687	taw requires that the death certificate be executed as been signed by the attending physician and a property should be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, any, teaching to inchesiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as b. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	s a consequence of) s a consequence of) s a consequence of) s of pregnancy 2	3 □Ectopic pregnanc, 5 □ Other (specify) □	y	23e. Did tob 1 ☐ Ye 24a. Was ar autops y perform	23d. Date of delive Month accolouse contribute to the solution of the solutio	Injuries Tery Day Year the cause of death? bably 4 Unknown posy findings available ampletion of cause of
P.O. Box 687	The law requires that the death certificate be executed at the seen signed by the attending physician and an page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	resulting in death) Sequentially list conditions, any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as b. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	s a consequence of) s a consequence of) s a consequence of) s of pregnancy 2	3 □Ectopic pregnanc, 5 □ Other (specify) □	y ven in Part I.	23e. Did tob 1 ☐ Ye 24a. Was ar autops y perform	23d. Date of delive Month accoluse contribute to the second seco	Injuries Tery Day Year the cause of death? bably 4 Unknown posy findings available ampletion of cause of
P.O. Box 687	The law requires that the death certificate be executed at the seen signed by the attending physician and an page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, ary, leading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	Due to (or as b. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown as contributing to death to the second of the sec	s a consequence of) s a consequence of) s a consequence of) s of pregnancy 2	: 3 □Ectopic pregnanc, 5 □ Other (specify) □	ven in Part I. 26. Place of Deat	23e. Did tob 1 Ye 24a. Was ar autops 1 Yes 2	23d. Date of delive Month acco use contribute to the second seco	Injuries Teny Day Year The cause of death? bably 4 Unknown Dopsy findings available ompletion of cause of 2 No
P.O. Box 687	The law requires that the death certificate be executed at the seen signed by the attending physician and an page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, ary, leading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death	Due to (or as b. Due to (or as d. Due to	a consequence of) a consequence of) a consequence of) a consequence of) a consequence of) a of pregnancy 2	3 Ectopic pregnancy 5 Other (specify) ne underlying cause gru atient 3 DOA Other	yen in Part I. 26. Place of Deatler: 4 □ Nursing Ho	23e. Did tob 1 Ye 24a. Was ar autops 1 Yes 2	23d. Date of delive Month accoluse contribute to the second seco	Injuries Teny Day Year The cause of death? bably 4 Unknown Dopsy findings available ompletion of cause of 2 No
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Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Edmund Riemer, Jr. Februrary 24, 2005 2:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 27 North South of Rt 407 Carroll Westminster Rt. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1√2 M 2 □ F Yrs Director 579-52-1499 14. Germany 64 1940 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10h. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant. It e Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll New Windsor the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2245 Doctor Stitely Road 21776 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2/☐ No Specify: by Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Builder 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Riemer, Sr. ပ Ella Zander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathryn Riemer (Spouse) 2245 Doctor Stitely Road New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 2/28/05 * 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD THATCHT AFUNERAL HOME & CHAPEL, PA (Box 195) 21. Signature of Funeral Service Licenses Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cases. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the a detached 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 No 24a. Was an rmed? 2□ No Yes Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 XYes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 → Other (Specify) Scune this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred could an virus vehicle After t Certification: 1 Natural death. -24-05 14:26M investigation Accident 3 Suicide 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 2+27 war 24 +07 (Crroll O 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) within 2 To the To the 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 02/25/2005 OCME

State Registrar

31. Date filed (Month, Day Yes

person who completed cause AU

111 Penn Street

Baltimore, Maryland 21201

of death (Item 23a) (Type, Print)

2005 Aller

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State of Maryland / Department of H	lealth and Mental Hygiene 🛭 🗍

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State of Marylar	nd / Department of Health and N	Mental Hygiene 115	06812
	Certificate of Death	Reg. No.	00012

			1 - State Registrar			Cei	rtificate	e of E	Death			Reg. No			000	1 5
	DI		1. Decedent's Name (First, Midd	le, Last)							2. Date of De	eath Dai		Vane	3. Time of	Death
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	Examir		4a. Fecility Name (If not institution		*		4b. City, T							of Death		
			10420 block of						ingto				Mont	gomer		
	Funeral Director		5. Social Security Numbelunk	6. Sex 1 X M 2 □ F	7. Age (In yrs. 39	last birthday) Yrs.	If Under	Days	If Under Hours	Min.	8. Date of Bi (Month, D Feb 17	th ay, $Y \theta ar$	65	9. Birthpl Coun Mexi		or Foreign
	and		Usuel Residence of Decedent 10a. State unk 10b. County	,	unk 10c. Ci	ty, Town or Lo	cation							1 10	d Inside C	ity Limits
	he Maryl 8a-f sho	Director			dik										1 ☐ Yes	2 No
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980	within 72 hours after death with the Maryland inen "natural", or Items 23s or 28s-f show then "belical Ever the fronts be multiped at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☒ Divorced	ried Armed Fo	2 (∄No ve		Was Decede f Yes, speci 1 X Yes 2	fy Cubar	spanic Ori n, Mexican Specify:	i, Puerto	ecify Yes or No Rican, etc.) Xican	0-	Blac	e - America ek, White, e : Whi	etc.	
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Maryland 21215-0036	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle,	Last)				ulik	18. Mothe	ers Name	(First, Middle	, Maiden	Sumam	e)		UIIK
	12 sh h and 7 Is m traum		19a. Informant's Name/Relations O.C.M.E.	ship (Type, Print)							More, Numb		r Town, 2120		Code)	
Baltimore,	Pages 1 and nent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☒ Other (5	3 □Removal from Specify) in St	State	Place of Dispo cemetery, cren	sition (Name natory or oth	e of her place	,)	C	ate	20c, Lo	cation -	City or Tov	vn, State	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Septile	dicense de I	irecto		ate and		•	<pre>bard 2120</pre>	655 W.	Ba1	timo	ore S	treet	
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	To the within 2. To the complet	Me	29b. Signature and atte of pertific	or/ ///	Λ		29c.	License	number			29d. Date	e signed	(Month, D	ey, Year)	
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			30. Name and address of person	OGAL		111		Stre	et,	Balt:	imore,	Mary	land	2120)1	
	Sta Registr		31. Date filed (Manth Day) Year	2005	egistrar's Signa	ty of	ule)									

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of Maryla		artment of H		nd Mental Hy	ygiene Reg. No. 20 ()5 06813
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Lass Janie Pauline Stal Aa. Facility Name (If not institution, give	llard		4b. City, Town, or	Location of [
	Funeral Director	CI	1600 Revell Downs 5. Social Security Number 6. Si 231-38-7723 1		s. last birthday) Yrs.	Annapoli If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B	Anne Ar	
	se Maryland	ctor	Usual Residence of Decedent	10c. C	City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	s 23a or 2	Funeral Director	10e. Street and Number 6533 Stephens Roa			10f. Zip Code 24293			10g. Citizen of Wh	
9800	ours after de iral', or Itam Evaniner i	ρχ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ Xio If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin n, Mexican, F Specify:	1? (Specify Yes or N Puerto Rican, etc.)		American Indian, White, etc. White
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ryland	0 = 5	To Be (17. Father's Name (First, Middle, Last) George W. Stacy 19a. Informant's Name/Relationship (1)				Sara	ah Bricke	·	
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Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service L cen) M	t. Zion	Church C Name and Addres Turgill F	Cem. 2	2-28-05	Pound, V	rirginia
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Division of Vi	ing Phy n. After this funeral d	ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursir	28d. Describe		Son's SpecifyResidence
DIVIS	lospital or Attano I hours after death unaral Diractor: sly filled in by the	0	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	building, etc. (Spec	ify)			City or To	wn, State)	or Rural Route Number,
	To tha Hos within 24 ho To tha Fun completely i	Medical	(Check only one) 29b. Signature and title of certifier	/sician: To the best of my kn inar: On the basis of examin and manner stated.	ation and/or inv	estigation, in my op 29c. License	number	occurred at the time,	date and place, and 29d. Date signed (A	due to the cause(s)
6	1/1	~	30. Name and address of person who o	100	МО m 23a) (Туре,		306	9.	February 2	24, 2005
	Sta Registr	te	Richard Bernstein, 31. Date filed (Month, Day, Year)	MD, 133 Def	ense Hw	y., #109,	Annar	polis, MD	21401	

			riedse i	Ctate of Manuford / Don			•	
			1 - For Stata	State of Maryland / Dep	artment of Health and Intificate of Death		2005	00011
-	-		Registrar 1. Decedent's Name (First, Middle, Last		Tuncale of Dealit	Reg. N	10/ U U J	3. Time of Death
	Physici	an	BRENDA	'	SHEARS	Month E	Day Year	
	/Medic		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Deat	12.70
	Examin	er	THE JOHNS HOPKINS	HOS PETAL	BALTIMORE CI		ior obtain, or boat	"
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		212.46.0798 1	M 2 X F Yrs.	Months Days Hours Mir	5-17-4	B M	arcilant
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		, ,,	10d. Inside City Limits
	faryla sho	2	MI		_			1 Yes 2 □ No
	the N	rect	10e, Street and Number	DUIT	10f, Zip Code	100.0	Citizen of What Co	untov?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show in Medical Examinat Institical at	by Funeral Director	3224 Polh	ONA ACTOMICIO	21213	1	151	,
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	
9	after or Ite	/ Fu	1 Never Married Married	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Yes 2 ☐ Specify:	no rican, etc.)	Specify: R	e, etc.
215-0036	ural',		3 Widowed 4 Divorced				D	ack
5	n 72 ł	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Give	dent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 16b.	Kind of Business/	Industry
212	within ene.	mc	Elementary Secondary (0-12)	College (1-4or 5+)	Aido	150	24500	Moitation
	filed with Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Maide	an Sumane)	1 12 1014
lan	Mental Mental arkad c	To B	Austhur Wo	Hins	Vor	1011 Ste	war +	<u>_</u>
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. If mea 27 is marked other than "netural", or Items 23e or 28e-f show other traumatic event, in Medical Ever the marked by notified at	_	19a. Informant's Name/Relationship (T)	pe, Print) (Dung Lier) 19b. Mail	ing Address (Street and Number or F	Rural Route Number, City	or Town, State, Z	ip Code)
	and 2 balth n 27 i		Shelley O. Hi	arvey 260	>1 Mura St	eet, Ba	HO ME	21213
altimore,	m 0 h		20a. Method of Disposition N Surial 2 ☐ Cremation 3 ☐ F	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	Date 20c.	Location - City or	Town, State
Ë			' 4 ☐ Donation 5 ☐ Other (Specify)	Wester	en (enetery 3)	/3/05 Ba	140 MI	21223
Ball	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licens	ee land	A Name and Address of Fability	se Frencer	al Ser	vices
	TO = 9 0		Will and		4905 YORK	Load, Bo	140 MI	2/2/2_ Approximate
			shock, or heart failure. List only of	ications that caused the death. Do not en ne cause on each line.		ac or respiratory arrest,		Interval Between Onset and Death
)	Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	EMBOLISM			10 DAYS
	Examiner			BREAST CANC	FR			2 YEAR)
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				2 /2/1105
	cuted nd ransit	Examiner	that initiated events	D				
760,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a consequence of):				
6876	cate b	dical		1				
9 ×	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy			0010	
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 Fetal death 3 €	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	Day Year
o.	that the de led by the a detached i	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown				
4	s that ned b s deta	by PI	Part II. Other significant conditions con	ntributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Records,	w requires been sign should be	ed b	ACUTE RENAL PAI	CURE		1 🗆 Yes	2 3 √0 3 □ Pro	obably 4 Unknown
00	law reas bee	ompieted	PULMONARY HY	PERTENSION		24a. Was an	24b. Were au	topsy findings available
R	The la cate has page 2	E O				autopsy performed? 1 ☐ Yes 2 📉	death?	ompletion of cause of
Vital		BeC	25. Was case referred to medical		26. Place of De	eath (Check only one)		
of <	di S	To	examiner? 1 Tes 2 No	lospital: 12 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Spec	sify)
0	ding Ph h. After th funeral		27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	ury occurred	
Sio	en eat or: or:	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
Division	after death after death Director: A	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
J	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by t		29a. Certifier Certifying Phy	sician: To the best of my knowledge, deal	th occurred at the time, date and place	e and due to the cause/	s) and manner as	stated
	24 hr 24 hr e Fun etely	edicai	(Check only 2 Medical Exami	ner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occ	urred at the time, date a	nd place, and due	to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month	, Day, Year)
			Christopher	Ingelmo	RES-000	FFQ	RUARNI	26 2001
Ì			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type		,,,,	1	26 2005 MARYLAND
	()		CHRISTOPHER INGELN	ID THE JOHNS HOPKI	NS HOSPITAL, 600 NO	ATH WOLFE S	TREET, BA	LTIMPRE 21287
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	TIEGISU	वा	IEINIM U NI /III	17) 8705 a. 107 A	Program I Add trans			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** STANLEY 2122 PM JOSEPH /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lower Her Boult in the Bo Examiner 4b. City. Town, or Location of Death 4c. County of Death University of 5. Social Security Number Maryland of 6. Sex Funeral 7. Age (In yrs. last birthday) 100 M 2□ F 16.64.7503 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23e or 28a-f show PACTIMORE 1 Nes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? or items as Decedent of Hispa Yes, specify Cuban, M med Forces? the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No If Yes, Give Year or Dates: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then College (1-4or 5+) Hygiene. item 27 is marked other other treumatic event, Eather's Name (First, Middle, Last, Pages 1 and 2 should be fill tment of Health and Mental Hitant: If item 27 is marked oth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health are cortant: If item 27 is injury or other treu Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death Check on on Hospital: 1 Inpatient Other: 2 XNo 2 ER/Outpatient 1 🗌 Yes 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 5893 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

Rogs ta

2005

31. Date filed (Month, Day,

Registrar's Signature

			1 - For State Registrar	State of Marylan	id / Depa		lealth and	•	•) n 5	0001
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last ELIZABETH 4a. Facility Name (If not institution, give	A. SCHROE		GLEN	r Location of Deal	12	eath Day 4c. Count		3. Time of Death 5. CO A M RUMDEL
	Funeral Director		5. Social Security Number 6. Se 216-16-8026	x 7. Age (In yrs. 81	, .	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	3. Date of Bi July 2	7,1923	9. Birthp Mary	place (State or Foreign Tand
	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "naturel", or Items 23e or 28e-f show event, if a Medical Evand we must be indified at	Funeral Director	10a. State 10b. County	rundel	Pasad		2		10g. Citizen of U.S.	What Coun	0d. Inside City Limits 1 □ Yes 2 ★ No http?
9800	iours after death	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ᠓ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ₹ No	Specify:			ce - Americ ack, White, o fy: Whi	etc.
Maryland 21215-0036	filed within 72 h Hygiene. Aher then "natu ant, It a Medicul	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12			dent's Usual Occup kind of work done DO NOT use retire lesperso		rking	16b. Kind of E		ept. Store
ryland ;	Mer Mer arke	To Be C	17. Father's Name (First, Middle, Last) Edward Meinek 19a. Informant's Name/Relationship (T)		10b Mails	ng Address (Street	18. Mother's Na	lla H	Elfrey		Code
	1 and 2 s Health ar em 27 ls ther treu		Louis E. Schroeder 20a. Method of Disposition 1 28 Bunal 2 Cremation 3 DR	(Son)	55 N	icholson sition (Name of natory or other place)	Drive,			and 2	21122
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Feneral Service Licens	Mea	idowrjd Mc	ge Mem P Name and Addre Cully-Po 204 Moun	ark 03-0 ss of Facility Tyniak F	uneral H	Elkridg Home P.A		00000
760,	Physician /Medical Examiner	icai Examiner	23a. Part. Enter the disease, or compose, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	uence of): uence of): uence of):	er the mode of dying	ng, such as cardia	c or respiratory a	urrest,		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed the sabeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent premant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fete 4 Pregnant at time of d	Ideath 3	Ectopic pregnanc	,	•		ate of delive	ory Day Year
ecords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.				ne cause of death?
α		Completed						1 ☐ Yes	psy ormed? 2 No	Were autor prior to con death? 1 Yes	psy findings available impletion of cause of 2 No
ion of Vital	hye his	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manny of Death 1 Actival 5 Pending investigation	Hospital: 1 Impatient 2 Impati	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 🗌 Nursing H				1)
Division	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After completely filled in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and Numi wn, State)	per or Rural	l Route Number,
	the Hosp hin 24 hou the Funer npletely fill	Aedicai	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	estigation, in my c	pinion, death occu	n, and due to the arred at the time,	date and place,	and due to	the cause(s)
6	20 2 ME 2	M	29b. Signature and Marof certifier 30. Name and address of person who certifiers	ompleted cause of death (1)	M.D.	29c. Licens	e number 5149 Glent		29d. Date signe		
· ·)(ato.	31. Date filed (Month, Day Year)	301 HTTCP U	al D	Yive (ylen to	Survie	MD	210	161
ė.	Sta Regist		MAD 02 20	99	K 6	railes					

amend item/19a b, per 19, Control of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month CARL **SUDER** 6:32 P **Physician** CLARENCE 24, 2005 Feb. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 11 East Barney Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 04 192 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M M 2 □ F **Funeral** Months 84 215-28-1020 Mary I and Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar actinent of Health and Mental Hygiene.
ortent: If item 27 is marked other than "natural", or Items 23e or 28a-1 show njury or other traumatic event, the Medical Examinant actine the inclinition. Baltimore N/A Maryland 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 11 East Barney Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Western Maryland 15. Decedent's Education (Specify only highest grade completed) Railway Elementary/Secondary (0-12) College (1-4or 5+) Conductor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora. Smith Suder Henry 195 Heyling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
12176 Cove Road, Clear Spring, Md. 21722 Deald Warra (Personal Rep.)
-Nathan Lucas (Nephew) 20b. Place of Disposition (Name of cometery, crematory or other place)
Parkhead Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03/05/05 Parkhead. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Cully-Polyniak Funeral Home, P O E. Fort Ave., Baltimore, Md. Department of any in 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONE /Medical Due to (or as a consequence of): **Examiner** DRONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cther (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? SE 24a. Was an has autopsy performed3 page 20 No 1 Yes 2 DAY certificate 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 3FI DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb-25-2005 DU2102 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORT BACTIMORE AUE Waves 0. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ²23,2005 11:15 A_M February STONE /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Pasadena 1974 Poplar Ridge Road Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 15 1944 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 💢 F 60 Mar Vland 216-42-1050 Director Usual Residence of Decedent 10a. State 10b. County ahow 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28e-f abov other traumatic event, the Moulcal Exprisiver manal be notified at Md. Anne Arundel Co. Pasadena Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1974 Poplar Ridge Road 21122 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Billing Coordinator Law Office 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 Is marked o Charles Milton Vincent Rineker Loretta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
and) 1974 Poplar Ridge Road, Pasadena, Md. 21122 Charles Gordon Stone, Jr. (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) injury or Loudon Park Maus. 2/28/05 Baltimore. Md. 21. Signature of Funeral Service Licensee ି (୯୯୩ୀ/୯୯୭୪ୀ ନିମ୍ନିଅନ Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. ny Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic disease or condition resulting in death) o months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Il-transit death certificate be executed Due to (or as a consequence of): physician a s the burial-Physician/Medical as ed by the attending properties of detached for use as IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 Other (specify) o 9 Unknown ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 been sign 2 X No Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy page certificate 1 Yes 2 2 Physician: funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Dear 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 AGNES EWCOLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2005

AKG	179		1 - For Amend Item	State of Mary 4c&Unpend It	land / Depa em 23a 27	rtment of F 28a-f p	lealth and er me G8 Death	Mental Hyd 3-3-0	giene 5 tas () ()	15 06819
	Physic /Medi		1. Decedent's Name (First, Middle, La Denern St					2. Date of Dea Month Februa	ath Day Y	3. Time of Death 005 3:58 P M
9	Examir		4a. Facility Name (If not institution, given University Hos	pital		4b. City, Town, or Baltim	ore	th	4c. County of	Death
216	Funeral Director			Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1, Year) 22,1980	Birthplace (State or Foreign Gountry)
	Maryland a-f show	tor	10a. State 10b. County Marylan Bautin	INCO 100	c. City, Town or Lo	SOCUE	 Ne			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ter death with the M Items 23a or 28a-f Increment be rediffe	ral Director	10e. Street and Number 2934 Lakebrao	K Apt. 104	7	10f. Zip Code	27	L	10g. Citizen of Wha	at Country?
36	irs after de il', or items zaminier in	by Funeral	11. Marital Status 1 D Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	ľ	Vas Decedent of H Yes, specify Cuba ☐ Yes 2☐ No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Black, V Specify:	American Indian, White, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Medical Examinar must be recitived at	Completed	15. Decedent's E (Specify only highest gr.	ducation	16a. Deced (Give	ent's Usual Occupi kind of work done of OO NOT use retired	ation during most of wo	orking	16b. Kind of Busin	ess/Industry
	2 should be filed withir and Mental Hygiene. is marked other than aumatic svent, the Ma	Be	17. Father's Name (First, Middle, Last)		ome Ma		me (First, Middle,	Domes Maiden Surname)	tic
Maryland	d 2 should th and Men 7 is marke traumatic	5	19a. Informant's Name/Relationship	Type, Print)	19b. Mailin	g Address (Street	DICAN and Number or R		r, City or Town, Sta	ite, Zip Code)
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tra	0	20a. Method of Disposition 1 Deurial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	Ob. Place of Disposicemetery, crem	sition (Name of patory on other place	panks	Date 12/45	20c. Location - Cit	y or Town, State
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Luneral Service Lice	1 -1 1	A = M	Name and Addres	so of Facility	tan Ch	may 192	Frost Dive
B	Pnysician		23a. Fart V. Ener the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line. Gunshot wo			g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a cor	nsequence of):					
_	cate be executed only sicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First in 3 ying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor						
68760,	tificate be eg physicier as the buri	edlcal		_ d.						
P.O. Box	Attanding Physician: The law requires that the death certificate be executed rideath. cotor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Jnknown	23c. If yes, outcome of pre 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not	t resulting in the un	derlying cause give	on in Part I.	23e. Did tol		te to the cause of death? Probably 4 □Unknown
Vital Records,	ician: The law re certificate has be ector, page 2 sho	Completed						24a. Was a autops perform		e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
of	g Physician: Th er this certificate ieral director, pag	n: To Be	25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient	3 DOA Othe	4 🗆 Nursing F		e) ance 6 Other (5 ow injury occurred	Specify)
Division	il or Attending lafter death. Director: After In by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A		A M 1□Y	res 2 X No	Subject 28f. Location (St. City or Town		r Bural Route Number, Lakebrook
	Hospita 4 hours Funeral ely fillec	Medical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	residence ysician: To the best of my niner: On the basis of exan and manner stated.	knowledge, death nination and/or inve	occurred at the timestigation, in my op	e, date and place	ircle,Ap	t.102,Lar	nsdowne, Md
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier			29c. License		2	9d. Date signed (M	onth, Day, Year)
			30. Name and address of person who			rint)	CME enn Stre	et Balti	more Ma	ryland 21201
di	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2	32. Registrar's S		Seek	5010	ce Darci	more, ria.	Ly101111 21201

ERNE ZONO 50L

> Box 68760, o. Division of Vital Records, P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Solomon Ernest. L. 05 7.14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, 6-14- Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral X**□M 2□F 215-90-7022 Md. Director 39 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. Item 27 is marked other than "natural", or itame 23a or 28a-f abor other traumatic event, it a Medical Examinar must be notified at 1 Yes 2 No Funeral Director NA Baltimore Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with USA 21239 1547 Winston Ave. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Be Completed by Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within ; the and Mental Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Squeaky Cleaning Maintenance 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Millie Newton Solomon Edward ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 end 2 s at of Health an if Item 27 is i 1547 Winston Ave., Baltimore, Md. 21239 Edward Solomon FATHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 Burial 2 Cremation 3 Removal from State ö Department fmportent: if eny injury or one Scotia, S.C. * 4 ☐ Peqation 5 ☐ Other (Specify) Melbourne Cem. 3-3-05 21202 21. Signatur of Funeral Service Licenses Baltimore, Md. 22. Name and Address of Facility 1101 E. North Ave. March F.H. East 23a. Pa 1. Enter the disease, or complications that caused the death, s'ock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Cause (Final disease of condition resulting in death) Pnysician 48 SEPSIS /Medical Due to (or as a consequence of): Examiner 48 hrs PNEUMONIA Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANOXIC ENCEPHALD PATHY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ho 24a. Was an autopsy performed page 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo 1 Yes 1 Impatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) s after de in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours af To the Funeral D filled the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22 RES-000 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHEWS 5601 2 EEBA LOCH RAVEN BOULEVARD, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Ma	aryland / De	partmen <i>ertificat</i>	t of H e of L	ealth a D <i>eath</i>	nd M		iene 20	05	0682		
			Decedent's Name (First, Middle, Last)							2. Date of Death		Vane	3. Time of Death		
	Physici /Medio		George	Thomas S	hankle, S	r.				February	, 22 , 20	ď55	3:00 AMM		
	Examin		4a. Facility Name (If not institution, give s	treet and number)				Location of	f Death		4c. County of Death				
			4006 Ballenger C				rede			Frede					
	Funeral Director		213 42 3402	7. Ag	e (In yrs. last birthd 60 Yrs	Months	Days	If Under 2 Hours	Min.	8. Date of Birth Mar • 10	, 1944		place (State or Foreign Lyland		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location						1	10d. Inside City Limits		
	Manyli f sho	5	Maryland Frederic	ζ.	-	derick							1 ☐ Yes 2 XNo		
	28a	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of W	hat Cour	ntry?		
	h with	0	4006 Ballenger	Creek Pi	ke		217	703			U.S.A	. •			
	deati	ner	11, Marital Status	2. Was Decedent Armed Forces?	Ever in U.S.	3. Was Dece	dent of Hi	spanic Orig	in? (Spe	ecify Yes or No- Rican, etc.)			can Indian,		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Modical Exercities from the rolling at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	12 Yes 2 If Yes, Give Year or Dates:	965-1971	1 ☐ Yes		Specify:	, ruello	rican, etc.)	Specify:	k, White, Wh	nite		
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. De	ecedent's Usua	al Occupa	ation	of worki	ng 1	6b. Kind of Bu	siness/In	dustry		
21	ithin	nple	Elementary/Secondary (0-12)	College (1-4or	5+) ' <i>iii</i>	ive kind of wo e. DO NOT u)	OI WOIN	1	T	<u> </u>			
	ygier lygier her th		17. Father's Name (First, Middle, Last)			Paint	er	40 14-41-4-	de Massa	(First, Middle, N	Painting		ractors		
Maryland	uld be fi Mental H nrked ot tic ever	To Be	Norman Arth	ur Shankl	e, Sr.					nce Mae		•/			
	nd 2 sho alth and 1 27 is me		19a. Informant's Name/Relationship (Type Mrs. Susan A. Sha							Pike, Fr	-				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dapartment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantiant must be notified at ance.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Feb.	24,	2005	oc. Location - 6 Frederi								
Balti	permit, Dapartn imports any inju		21. Signature of Funeral Service License	Basfo	ord	PA Funer	al Home	e 1 21	701						
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused	the death. Do not	enter the mod	le of dyin	g, sych as c	cardiac c	or respiratory arre	st,		interval between		
	Pnysician	0.1	Immediate Cause (Final disease or condition	metas	tertice e	Sopho	ice	2	Ca	n cer	_		Onset and Death		
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	cate be executed physician and the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as	a consequence of):							=			
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000	s bee	Completed								24a. Was ar	24b. W	ere auto	ppsy findings available		
Re	The law ate has page 2:	mo								autopsy perform	ed? de	eath?	mpletion of cause of 2 No		
Vital		a	25. Was case referred to medical					26. Place	of Death	(Check only one			2010		
of V	d is	To B	examiner? 1 🗆 Yes 2 📉 No	ospital: 1 🗌 Inpati	ent 2 ER/Outpa	tient 3 DC	Othe Othe	er: 4□ Nur	rsing Ho	ne 5 Reside	nce 6 🗆 Othe	r (Specif	(y)		
0	ding Phy. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ıry 28b. Tim y Year) Inju	e of 2	28c. Injun Worl	at	-	28d. Describe ho	w injury occurre	bd			
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Division	ei or Att s aftar d il Direct d in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ury - At hom <i>e</i> , farm c. <i>(Specify)</i>	street, factor	y, office			28f. Location (Str City or Town		r or Rura	al Route Number,		
	To the Hospitel or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Phys		f examination and/o										
	To the within To the comp	ž	29b. Signature and title of certifier	2/12	MD	290	c. License	number	//	29	d. Date signed	(Month,	Day, Year)		
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	8		30. Name and address of person who co EIHAMY ESKA	inder, M	10 5	pe, Print)	7th	streé	+	Freder	ick, M	2	1701		
	Sta Regist	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy Eskander, Mo 501 W Th street Frederick, ND 21701 State strar 31. Date filed (Mohth, Day, Year) MAR 02 2005													

			1 - For State Registrar	State of M	arylan	-	artment o			and M	F	Reg. No.	0() 5	068	22
н	Physici	ian	Decedent's Name (First, Middle	•							Date of Dea Month	Day		Year	3. Time of I	
	/Medi		Richard	Leroy		tarner					Februa			2005	9:15	p ^M
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	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City	y Limits
	Many f sh	Ď	MD Anne	Arundel	M-	illers	71110								1 🗌 Yes	2 X No
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	3a ou	ā	1697 Millersv	rillo Pond					100						,.	
	ms 2	Funerai	11. Marital Status	12. Was Decedent		.S. 13. V	Was Decedent	211		ain? (Spe	cify Yes or No-		SA 4. Race	- America	n Indian	
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8	al', c	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		'	l∐Yes 2.2Ž	No	Specify:			5	Specify:	Whi	te	
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Maryland 21215-0036	0 a a 0	Be	17. Father's Name (First, Middle, L	ast)							(First, Middle,	Maiden S	umame	a)		
<u>\}</u>		2	Roy Starner								Watkins					
Jar	O1 (0) An M		19a. Informant's Name/Relationsh								l Route Numbe					
	s 1 and 2 if Health item 27 i		Bonnie Starner	(Daughter)	001 5				ille		d, Mill					}
0	of in		20a. Method of Disposition 1 □ Burial 2 🂢 Cremation	3 Removal from State	200. P	emetery, cren	sition (Name on natory or other	or r place)				20c. Loca	ation - (City or Tow	n, State	
Ë	tmen tant: jury		`4 □Donation 5 □ Other (Sp	ecify)	Met		matory				/2005		timo	re, l	MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	icensee		22	Name and A Hardes	ddress Ly	Fune:	ral	Home, P , Annap	.A.	МТ	21/0	1	
			23a. Part1. Enter the disease, or o	complications that caused	the death	n. Do not ente	er the mode of	f dying,	, such as o	cardiac o	r respiratory arr	est,	<u>المالا</u> و	7	Approximate	
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	/Medical		disease or condition resulting in death)	a. Due to (or as b. Due to (or as	a consequ	uence of):			,					-		
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Вох	death certifica e attending ph id for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth			Ectopic pregna	ancy				23		of delivery		
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a	iician: Th certificate rector, pag	e Co	OS Man annual to market								1□ Yes →	No			□ No	
Ξ		0	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:			- I	Other:			(Check only on			-		-
ō	Phys	: To	27. Manner of Death	1 ☐ Inpatie		ER/Outpatient 28b. Time of		Injury a	4 Nur		ne 5 Reside			(Specify)		
o	iding Phy th. After thi funeral o	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	y Year)	Injury		Work?	s 2 □ N				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•		
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could no	ot be	ury - At ho	me, farm, stre					8f. Location (St	reet and l	Vumber	or Rural F	Route Numbe	er.
ā	in Dir	Certification:	4 Homicide	building, etc	c. (Specify)					City or Towr	, State)				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Sertifying	Physician: To the best	of my know	wledge, death	occurred at th	ne time,	, date and	place, a	nd due to the ca	ause(s) ar	nd manr	ner as state	ed.	
	he H in 24 he Fi	edical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examinati ited.	ion and/or inv	estigation, in n	ny opir	nion, death	occurre	d at the time, da	ate and pl	lace, an	id due to th	ie cause(s)	
	To To To To To To To To To To To To To T	7	29b. Signature and title of certifier	5 Po		, ~ 1	29c. Lic	cense r	number	~	2	9d. Date s	signed ((Month, Da	y, Year)	
)	0/		maria	C. 100	ne	w n	(1)	12	206	de	15.3	02	2/2	481	OC	-
	10		30. Name and address of person w	ho completed cause of do	eath (Item	23a) (Type, F	Defe Defe	0 50	bir	6.1	ay Er	ita	m	An	ma D),(
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signat	ure 🖍	a serie	n de	MI	10	ay si	N IE	1116	hol :	21160	15
	Registr	-	MAR 0 2 201	32. Registra	J.	April	E 2				٧				7	

Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the hirral-tran Box 68760, P.O. Division of Vital Records, has this After or Attending death. after death Diractor:

SNYDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 21 2005 Steven Snyder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSPITAL BURNIE ARUNDEL GLEN ARUNDEL ANNE If Under 24 Hrs. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year)
Feb. 27,1962 Birthplace (State or Foreign Country) Days Hours 1**∑** M 2□ F Yrs Director 215-84-3966 Maryland Usual Residence of Deceden 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 No Anne Arundel Odenton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 527 Queen Ann Avenue 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic avant, the Madical Examiner 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Snyder Irene Fansler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health a Irene Snyder (Mother) 527 Queen Ann Avenue, Odenton, MD 21113 If itam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department o Important: If any injury or once. '4 □ Donation 5 XOther (Specify) Entombment Cedar Hill Cem. 2-25-2005 Brooklyn, MD 22 Name and Address of Facility Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HAMOLYTIC ANEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEVER Sequentially list conditions, Examiner Due to for as a if any leading to immedicause. Enter Underlying Cause (Disease or injury COAGULOPATHY that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 20 No Yes Be 25. Was case referred to medical 26. Place of Death Check only one) examiner 1 ☐ Yes 2 No Other: 2 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 296. Signature and title of certi 29d. Date signed (Month, Day, Year) 1)0055703 30. Name and address of er rson who completed cause of death (Item 23a) (Type, Print) BERHANE HOSPITAL NORTH ARUNDEZ 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 2005 DHIVIH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	3	.ate of Maryland /	Certificate of	Teaith and Mental	Reg. No. 200	fores and	
Dhysisis	Decedent's Name (First, Middle, Last)			2. Date of	of Death	3. Time of Death	
Physiciar /Medica		113 Sper	ncer		Day Year Vea	5 7:45pm	
/ Examine				4b. City, Town, or Location of L			
	5. Social Security Number 6. Sex	·	irthday) If Under 1 Year	Westminste		1011	
Funeral Director	5. Social Security Number 220-18-1261 Usual Residence of Decedent	7. Age-#h yrs. last b	Yrs. Months Days	Hours Min. 8. Date of Month May	of Birth (1912) 9. B	irthplace (State or Foreign Country) A	
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or thems 23a or 23a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once. To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li					10d. Inside City Limits	
	MD Carroll Westminster					1 ☐ Yes 2 ☐ No	
	10e. Street and Number	· ·	10f. Zip Code		10g. Citizen of What (Country?	
	1234 Washington Road 21157			'	US	A	
	11. Marital Status	Vas Decedent Ever in U,S. armed Forces?	 Was Decedent of I If Yes, specify Cub 	lispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc.	r No- 14. Race - An Black, Wh	nerican Indian, nite, etc.	
	3 ♥ Widowed 4 Divorced	☐ Yes 2 M No Yes, Give Year or Dates:	1□Yes 21∏ No	Specify:	Specify: W	,	
	15. Decedent's Education (Specify only highest grade completed)		. Decedent's Usual Occupation		16b. Kind of Busines	16b. Kind of Business/Industry	
	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			d)			
	11 17. Father's Name (First, Middle, Last)		Homemaker		Domesti	С	
	Earley V. Alger Rebec			18. Mother's Name (First, Mic Rebecca Goo	me (First, Middle, Maiden Surname)		
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num. Mrs. Sandra Orye (Niece) 6857 Beach Road Warrenton,						
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) 20c. Location - City or Town, State						
	1 Description 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 2/2/8/05 Frederick, MD						
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)						
Dem Depe I was	Duan L. Ha	ight	Sykesvill	e, MD 21784 (4	10)-795-1400	ox 195)	
						Interval Between	
Physician // /Medical	Immediate Cause (Final					Onset and Death	
Examiner	disease or condition resulting in death) a	Sepsis				34312	
		Due to (or as a consequence of):					
tificete be executed up physician and es the bunel-transit	Sequentially list conditions,	b					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events					1	
cete b	that initiated events resulting in death) Last	Due to (or as a consequence of):					
ding page 8	d					 	
eath cert ettendin Ifor use							
hysician: The law requires thet the dhis cartificate has been signed by the aldirector, page 2 should be deteched. To Be Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Completed by Physical Complete Completed by Physical Complete Compl	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death?		
					1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown		
						Were autopsy findings	
					erlormed?	available prior to completion of cause of death?	
				1	□Yes 2MNo	1 ☐ Yes 2 ☐ No	
	25. Was cese referred to medical 26. Place of Death (Chack only one)						
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Monursing Home 5 Residence 6 Other (Specify)						
	27. Manner of Death 1 ✓ Natural 5 ☐ Pending		Firme of 28c. Injury Work		be how injury occurred		
Attanding For death. Sector: After by the funer. Ification:	2 Accident investigation 3 Suicide 6 Could not be						
2 0 5	4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide				8f. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospital or A within 24 hours efter within 24 hours efter To the Funeral Dire completely filled in b Medical Certi	29a. Certifier (Check only Check only 2 Madical Fxaminer: On the basis of examination and/or investigation in my opinion double to the cause(s) and manner as stated.						
ithin 24 or the F omplete	one) and manner stated.						
C i i c	29b. Signature and title of certifier 29c. License number			_	29d. Date signed (Month, Day, Year)		
11/1	X VVN J	1/1/2	1	59943	February 2	24,2005	
010	30. Name an laddress of person who complete		(Type, Print) Y Ave. 5	ite 307 west	minster, M		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	-		1 /		
Registrar	1680 D 2 200	5 Per	10 1 12				

DHMH 16 Rev 6/95

			1 - For Stata Registrer		ryland / Dep <i>Ce</i>	artment of F rtificate of		R	eg. No2 () ()	5 06825
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Lasi CAME. 4a. Facility Name (If not institution, give	CULLY			or Location of Death	2. Date of Deat Month	Day	
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday, Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 9 1	Year)	9. Birthplace (State or Foreign Country)
	with the Maryland or 28a-f ehow be notified at	Funeral Director	10a. State 10b. County Md Carroll 10e. Street and Number		10c. City, Town or L Sykesvil			11	og. Citizen of Wh USA	10d. Inside City Limits 1 1 Yes 2 □ No at Country?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f ehow with jnjury or other treumatic event. I'm Medical Exatrates rust be notified at ance.		710 Obrecht Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. white
d 21215-0036	filed within 72 ha Hygiene. sther than "netu ent, I've Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10	ucation le completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired Omemaker	nation during most of work d) 18. Mother's Name	ing	domestic	,
Maryland	d 2 should be the and Mental the and Mental 7 Is marked of the umarked the treumatic ever	To Be	Francis Duben 19a. Informant's Name/Relationship (7) Kathleen Armstrong					et Woita al Route Number,	S City or Town, St	
Baltimore, I	t. Pages 1 and thent of Healt 14 item 2 iury or other i		20a. Method of Disposition 1 □ Disposition 1 □ Cremation 3 □	Removal from State	20b. Place of Disponsion St. Andre	osition (Name of matory or other place ews Cemete	ery 2-25-	Oate 2	oc. Location - Ci elevan,	ty or Town, State
Ba	Departicon la la la la la la la la la la la la la		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complete	ferbert	1 4	O. DOX I	JJ BYKESV.	rire, na	21/04	e & Chapel
	Pnysician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a END	STAGE consequence of):	175		or respiratory arre	3t,	Interval Between Onset and Death
8760,	death certificate be executed e attending physician and for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	o	consequence of):					
.O. Box 6		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1∐Live birth 2 4∐Pregnant at ti 9∐Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	of delivery Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	· _/	ite to the cause of death? Probably 4 Unknown
Vital Record	The law ate has b page 2 sl	e Completed	25. Was case referred to medical				26. Place of Death		ed? prio	e autopsy findings available r to completion of cause of th? Yes No
ð	ding Phys h. After this funeral di	ertification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work	er: 4 Aursing Hor	me 5 Resider 28d. Describe hov		Specify)
Division	spitel or ours afte leral Dir filled in	O	3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physics	building, etc.	my knowledge death	Occurred at the tim	ne date and place a	City or Town,	State)	or Rural Route Number,
ŀ	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 ☐ Medicel Exeminate) 29b. Signature and little of certifier	ner: On the basis of e and manner state	xamination and/or in	estigation, in my op	oinion, death occurre	ed at the time, dat	e and place, and d. Date signed (M	due to the cause(s) fonth, Day, Year)
1			Min S. Dake	mpleted cause of dea	Object	of Rona	15/k	esville	MD	23,2005
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 200	32 Registrar	s Signature	ale	ℓ			

			For	State of Ma	aryland / [Department of	Health and M	fental Hyg	jiene		
			1 - State Registrar			Certificate o	f Death	R	eg. No. 🤈 [ME	00000
	Physic /Medi		1. Decedent's Name (First, Middle, L Joyce /	ast)	Sampsi	n		2. Date of Dea Month Februar	Day	Year 2005	3. Time of Death
	Exami		4a. Facility Name (If not institution, gi	ve street and number)			, or Location of Death	1 - 1 - 100/		y of Death	. 0
_			Saint Agne	s Hea	Ithcari	e Bal	timpre	,	NIA		
	Funeral Director		217-56-5998	Sex 7. Age	e (In yrs. last birt			8. Date of Birth (Month, Day) Oct. 19	Year) 1950	Count	lace (State or Foreign try) NIA
	and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					
	Aaryli sho	5								10	0d. Inside City Limits 1 ✓ Yes 2 ☐ No
	the 28a-	Director	MD NA 10e. Street and Number		Baltim	10f. Zip Code					
	With Sa or		- 11	RD. 2122	0	2/22			0g. Citizen of	What Count	try?
	deeth with the Maryland ms 23a or 28a-1 show Fritting et	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?					USA 14 Ba	ce - America	an Indian
OCCO TACAC	je 🚅 🚆	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	If Yes, specify Cu	Hispanic Origin? (Spetban, Mexican, Puerto o <i>Specify:</i>	Rican, etc.)		ick, White, e	etc.
-	72 ho	ted	15. Decedent's E	ducation	16a.	Decedent's Usual Occ (Give kind of work don	upation		16b. Kind of E	Business/Ind	ustrv
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č	ed wi	ပ္ပ	lath		L	etter L	a RRIER	/	Post C	PFICE	9
7	be fit dot	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	101.			
	y la y la nould t Men narke	2		185			Nary	Hlice	Ower		
3	Vial d 2 st h and 7 ts n treun		19a. Informant's Name/Relationship		19b.	Mailing Address (Stree	et and Number or Rura	I Route Number,	27 11		_
-	Healt Healt em 2		20a. Method of Disposition	ipson_	20h Place of	718 Disposition (Name of	colborne	Ka.	Balto.		21229
	of a see		1 Burial 2 □ Cremation 3	Removal from State	cemetery	r, crematory or other pl	ace)		20c. Location	,	
-	artme artme orteni injury	10	'4 □ Donation 5 □ Other (Special Signature of 5 neral Service Lice		mt. Zi			05 L	ansdou	one, h	70
å	Deg ming	. 12	1 /m////	lord		22. Name and Add	PCH FH 2701	Foodh I thr	Dass Br	ilta.ma	21229
			23a. Part 1 Enter the alsease, or con shock or beart failure. List only	plications that caused	the death. Do no	ot enter the mode of dy	ring, such as cardiac o	r respiratory arre	st,	100	Approximate
	Pnysician		Immediate Cause (Final disease or condition	1.11	na 1	ancer				4	Interval Between Onset and Death
	/Medical		resulting in death)	a Due to (or as a	a conse uence o						11/11/1/
	Examiner		Sequentially list conditions,	b	100000						
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	f):					
	and erran	кат	that initiated events resulting in death) Last	c		0					
) 6	be executed sicien and burial-transit		,	Due to (or as a	a consequence of	r):					
12/4 E 27/6	physi physi	edicai		d							
200	ath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcome of	of Dregnancy						
0	eath cer attendin for use	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death	3 ☐Ectopic pregnand 5 ☐ Other (specify)	су			te of delivery onth D	y Day Year
50	that the ded by the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	and or death	3 Other (specify)					ŕ
ν <u>α</u>	The law requires that the death certificate be executed ase has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/M	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause gi	iven in Part I.	23e. Did toba	acco use cont	ribute to the	cause of death?
Wegord	een si							1 ☐ Yes	2 ☐ No	3 Probab	bly 4 Unknown
≥ 3	has be	Completed					_	24a. Was an		Were autops	sy findings available
. ~~		Con						perform	ed2	death?	pletion of cause of
	Physician: Th this certificete ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death				2.10
7	hysi this o	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien		eatient 3 DOA	her: 4 🗌 Nursing Hom	e 5 ☐ Resider	ice 6 Oth	er (Specify)	
7	ing P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir Inj	ury Wo	ry at 2	8d. Describe hov	v injury occurr	ed	
3.4 Sign	ttend death tor: , the f	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b]Yes 2□No				
) is	after of Direct of in by	Certification:	4 Homicide determined		ry - At home, farn (Specify)	n, street, factory, office	2	8f. Location (Stre City or Town,	et and Numb State)	er or Rural F	Route Number,
	lospite hours unerel		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge,	death occurred at the ti	ime, date and place, a	nd due to the cau	ise(s) and ma	nner as state	ed.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director,	Medical	29b. Signature and title of certifier	niner: On the basis of e and manner state	examination and	or investigation, in my	opinion, death occurre	d at the time, dat	e and place, a	and due to th	ne cause(s)
	+ 3 + 8		Daniel A			, Loen	18609	1/	2 \ \ \ \ \ :	nwionin, Da	100
	2	-	30. Name and address of person who	completed cause of dea	ath (Item 23a) /T	vne Print)	1000	U	2/01	Idu	103
_	210		Daniel Ab	raham	am (nem 23a) (1		n Ave,	Baltin	nore	21	229
	Stat Registra		31. Date filed (Month, Day, Year) MAR 0	2 2005 32. Registra	Signature	H had	,				
		- 1	man v	- LUUJ / Note	ACCEPTED A	ATTANCE.					

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE	JU5 0
CERTIFICATE OF DEATH	REG. NO.	

,		1 - STATE STATE OF MARYLAND REGISTRAR	/ DEPARTMENT OF H	EALTH AND MEN DEATH	TAL HYGIENE 2 REG. NO.	005 06827			
		1. DECEDENT'S NAME (First, Middle, LBSt) $SCHAPIRO$ 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. 1) $CIGCONSTANCE = 100000000000000000000000000000000000$	lest birthday) IF UNDER 1 YEAR YRS, MONTHS DAYS	IF UNDER 24 HRS. 7. D.	ATE OF DEATH DAY SES 28 2 ATE OF BIRTH 10018/1924	S. BIRTHPLACE (Stete or Foreign			
, 2, 3 should	стов	98. FACILITY NAME (If not institution, give street and number) BRIGHTWOOD NURSING HOME RESIDENCE OF DECEDENT		R LOCATION OF DEATH	9c. CO	UNITY OF DEATH _TIMORE			
permit. Pages 1,	DIRE	106. STATE 106. COUNTY BALTIMORE	OWINGS MILLS			10d. INSIDE CITY LIMITS? 1 YES 2 NO ITIZEN OF WHAT COUNTRY?			
nsit	FUNERAL	10 RICHMAR ROAD APT. 12 F 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	2.	1117 ENDENT OF HISPANIC OF	IGIN? (Specify Yas or No-	U.S.A.			
attending physician ise as the burial-trai	ETED BY F	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 15. DECEDENT'S EDUCATION 168. (1 YES	N I	16b. KIND OF BUSINESS/II	Black, White, etc. Specify:WHITE			
hospital or ached for u	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during mos ife. Do NOT use retired.) HOMEMAKER		OWN HOMI				
ed by	BE	LEON RO 198. INFORMANT'S NAME (Type/Print)	GAN 19b. MAILING ADDRESS (Street a)	JEANETTE	COHEN	Zip Code)			
Page 6 may be retain ral director, page 5 shoi iner must be notifi	10	1 A Burisi 2 ☐ Cremetion 3 ☐ Removal from State cemeter/to	1065 PARK AV EAND DATE OF DISPOSITION (Nat RET' OF THEOH CO	me of		- City or Town, Stats			
r death le fune al.		21. SIGNATUSE OF FUNERAL SERVICE LICENSEE	22. NAME AN	D ADDRESS OF FACILITY	S OF FACILITY SOL LEVINSON & BROS., ERSTOWN RD. BALTIMORE, MD 21				
ecuted within 24 hours after completely filled in by the burial, cremation, or removal atlc event, the medical		23. PART I. Enter the diseases, or complications that caused the shock, or heart failure. List only one seuse on each list IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Due TO (OR AS A CONSTITUTE OF THE CONSTITUTE OF THE CONSTITUTE OF THE CAUS	DEOUENCE OF):		cardiac or respiratory a	Approximate interval Between Onset and Death			
ith certificate be execute tending physician and coal Hygiene prior to burian or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONS	hyvoidism sequence of:	1 7 80 61		years years			
requires that the death sen signed by the atte of Health and Mental shows any Injury,	MEDICAL C	PART II. Other significant conditions contributing to death but not	t resulting in the underlying	cause given in Part	24s. WAS AN AUTOPS PERFORMED? 1 YES 2 NO	Y 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO			
The law ate has beate Oept.	HYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient	ACE OF DEATH (Check only one) OTHER:	UNCERTAIN E					
NG PHYSICIAN: ther this certific eath with the Si marked, or II	ву РНУ	27. MANNER OF DEATH Natural 5 Pending	28b. TIME OF 28c. INJURY WO	JRY AT 28d. RK? ES 2 NO	DESCRIBE HOW INJURY O				
OR ATTENDING DIRECTOR: After hours after death	COMPLETED	4 Homicide determined building, atc. (Specify)	home, farm, atreet, factory, office		LOCATION (Street and Numb City or Town, State)				
HOSPITAL FUNERAL Within 72		2 MEDICAL EXAMINER: Dn the basis of examination end/o	or Investigation, in my opinion, de	eath occured at the fime,	date and place, and due to	fhs cause(s) and manner as stated. ATE SIGNED (Month, Day, Year)			
TO THE DO THE DE FINED	TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	TEM 27) (Type, Print)	D00531	so Di	FEB 28012005			
21		31. DATE FILED (Month, DATE) 0 2 2005 REGISTRAS SIGNATURE	the Angelia	CLLIC	011 47	7704042			

			riease i			k indelible ink		•	3	
			1 - State	State of Mary		Department of I		Mental Hy	giene	00000
			* Registrar			Certificate of	Death		Reg. No LUU	06828
	Physici /Medic		Decedent's Name (First, Middle, Last) Robert L. Tyson					2. Date of De FOYUG	ry 27, 200	3. Time of Death 4:30 A M
	Examin	er	4a. Facility Namp (If not institution, give s MOYU AND JENE	etreet and number)	pita	Baltin	OF Cocation of Dog	i+V	/ 4c. County of De	ath
	Funeral Director		5. Social Seeurity Number 6. Sex 1245-26-5446	M 2□F 7. Age (In		thday) If Under 1 Year Months Days	If Under 24 Hr Hours Mir		ay, Year) (rthplace (State or Foreign Country) th Carolina
	pu *		Usual Residence of Decedent 10a, State 10b, County	100	c City Town	n or Location				40d tariff Circlinia
	shor	ក			c. City, Town	Baltimore				10d. Inside City Limits 1 XYes 2 No
	the N	Director	MD NA 10e. Street and Number						10- 00	
	death with the Maryland rms 23a or 28a-f show rmst Le riciffica at		1304 Pennsylvania Aver	me Ant A5		10f. Zip Code 21217			10g. Citizen of What (ountry?
	ns 23	Funerai		2. Was Decedent Ever Armed Forces?	in U.S.		Hispanic Origin? (Specify Yes or No	USA 14. Race - An	rencan Indian
0	or Iter	Fun	1 ☐ Never Married 2 ☐ Married	1 XYes 2 No		13. Was Decedent of I		rto Rican, etc.)	Black, Wh	
3	rel', o	l by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B1	ack
15-UU36	be filed within 72 hours after death with the Marylar lat Hygiene. d other then "naturel", or Items 23a or 28a-f show event, the Medical Examere must be relified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's Usual Occur (Give kind of work done	pation during most of we	orkina	16b. Kind of Busines	s/Industry
7	vithin ne. hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire Chef	nd)		Governm	ent
Z	filed v Hygie ther t	Co	12 17. Father's Name (First, Middle, Last)			GEI	19 Matheda No	mo (First Middle	, Maiden Sumame)	
yland		Be c	Robert Tyson				10.1410(1161 3 142	Sara Davi:		
	should nd Me mark matik	2	19a. Informant's Name/Relationship (Type	oe. Print)	19h	Mailing Address (Street	and Number or F			Zin Codel
Mar	s 1 and 2 should f Health and Mer item 27 le marke other treumatic		Karen Johnson/ Daughte			12 Orleans Str				2.6 0000)
อ์	of Health of Health litem 27 r other tr		20a. Method of Disposition	21		Disposition (Name of y, crematory or other pla		Date	20c. Location - City of	r Town, State
baitimore,	permit. Pages Department of I Importent: If its any injury or or once.		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			on Forest Vete		8-05	Owings Mills	, MD
<u>=</u>	mit. partm porte y inju		21. Signature of Funeral Service License			22. Name and Addre	ess of Facility			
מ	8 8 E 8		June la Van	مه		Wylie Funer	al Home 63	8 N. Gilmo	r St. Balto,	MD 21217
	Physician	_	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the	Olic	ot enter the mode of dyi		ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Tosuling in deality	Que to (or as a co	nsequence	of):				
	100	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to for as a co.	isoque ice i	πj.				
	uted d ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	Shock	Li	Ver				
ĵ	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a cor	nsequence	of):				
2/00	icate be executed physician and s the burial-transit	licai	d							
X OX	entific ling p e as l	Mec	IF FEMALE:							1
.O. BOX	law requires that the death certificate t as been signed by the attending physis 2 should be detached for use as the t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 Ectopic pregnanc 5 Other (specify)	y		23d. Date of di Month	blivery Day Year
7.	s that ned b s deta	by Ph	Part II. Other significant conditions con	tributing to death but no	t resulting in	the underlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ĕ	quire on sig uld b	ed b	Prostate Canci	er, Chro	nic	Anemia,		101	Yes 2 DNO 3 DF	robably 4 Unknown
Hecords	aw re s bee 2 sho	Completed	Hupertension	,		,		24a. Was		utopsy findings available
_	9 - 9	E O							rmed? death?	completion of cause of s 2 No
VItal	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of De	ath Check only		20.110
> 	Physic this ce al dire	To	1 Yes 2 No	ospital: 1 Inpatient	2 ER/Out	tpatient 3 DOA Ott	ner: 4 Nursing	Home 5□ Resid	dence 6 □Other (Sp	ecify)
	Attending Physician: r death. sctor: After this certific. by the funeral director,	on:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. T	ime of 28c. Injur	ry at		now injury occurred	
VISION	Attending or death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 ☐ No			
<u> </u>	after of Direct of in by	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (Si	At home, fai pecify)	rm, street, factory, office		28f. Location (5 City or Tov	Street and Number or F vn, State)	lural Route Number,
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	dical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exa and manner stated.	knowledge mination and	, death occurred at the til d/or investigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and the of certifier			29c. Licens	se number	. /	29d. Date signed (Mon	th, Day, Year)
		2	1 7 1000	703.	- 1000		29.	543 1	February	27, 2005
?	1		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type, Print)	1.	111	11.1	~, ~~
L	11.0		Klaine trazier	M.D. C/	2 /Yi	arylund i	sener	a/ HUS	pital	
ŀ	Sta Registr	- 6	31. Date filed (Month, Day, Year) MAR 0	2 2005 A	ignature	It Soul	ر	, 4	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrer AMEND ITEM #10c PER FH G841 3/02/05 JH Reg. No. 2. Date of Death **Physician** Tomoney Naomi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BATIMORE NURSING HOME If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 218.18.947 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at DALTIMORE 1 ☐ Yes 2 No Director REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 , or Items 23a Funera 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Yes 2 No BLACK ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life_DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) COSMETOLOGY College (1-4or 5+) COSMETOLOGIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked o MCKEE 19. Mailing Address (Street and Number or Rural Route Number 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 2.26.05 WOODLANN, MAXYLAND ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility VAVGHIN C. GREENE FUNERAL HOULE BALTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Agranulocytosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Dther (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an 212 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 20 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation unerel Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funerel I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State

N.S. Rajapakse, MO 25 Main Street 32 Registrar's Signature 31. Date filed (Marian Day Y 5/1) 2005

30. Name and address of person wood completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

Sulfe 200

D0057465

, Reisters town

29d. Date signed (Month, Day, Year)

MD

124/05

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 24, **Physician** 2005 Morris Oscar Trott 10:00am M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2011 Harman Avenue Baltimore Baltimore City 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Min. Months Hours **Director** 215-03-1995 April Ź8, 1916 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ir than "netural", or items 23a or 28e-f show the Medical Examinar must be notified at MD Baltimore City Baltimore Director 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2011 Harman Avenue 21230 death v USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after I ∰Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ WWII 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than " ury or other treumatic event, Ite Mes Elementary Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Trott ဂ Howard Schmidt Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sarah Ethel Trott (Wife) 2011 Harman Avenue Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State artment ortent: I * 4 ☐ Donation 5 ☐ Other (Specify) New Oakland Cemetery 3/1/2005 Sykesville, MD permit.
Departr
Importe
any inju 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) all Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician corone ear /Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown n signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes I or Attending Physicien: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 Z No 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RO#105 MO COPWIN 4600 ANNATOLIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0.22005

Dawn Woody 05-1304 DOS

		For State Registrar	State of Maryla	-		of Health and of Death		jiene .ag. No.2005	0683			
Physicia		1. Decedent's Name (First, Middle, Last) Dawn Michelle	Woody				2. Date of Dea Month Februar	th Day Year	3. Time of Death			
/Medic Examin		4a. Facility Name (If not institution, give s Prince Georges Hosp				wn, or Location of Dea		4c. County of Dea Prince G	th			
Funeral Director		5. Social Security Number 228-11-3298 6. Sex	M 2∑F 7. Age (In yrs 30	s. last birthday) Yrs.	If Under 1 Months D	rear If Under 24 Hr ays Hours Mir			thplace (State or Foreign puntry) hington, D			
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		City, Town or Lo				10d. Inside City Limit 1 ∐ Yes 2 ∑ N				
with the has or 28e-	Direct	10e. Street and Number 10808 Pookey Way			10f. Zip Co		1	10g. Citizen of What Co	ountry?			
d within 72 hours after death with the Maryland piene. r then "naturel", or items 23e or 28e-f show then "wallon Evantraer must be retified at the Medical Evantraer must be retified.	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Deceden	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)					
within 72 houinne.	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual (kind of work DO NOT use	done during most of w retired)	orking	16b. Kind of Business				
be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Earnest Hughmanly V				18. Mother's N	ame (First, Middle, a Magnoli	Maiden Sumame)	.0			
s 1 and 2 should be f Health and Menta item 27 Is marked other treumatic o	F	19a. Informant's Name/Relationship (Type Brenda Starks Wood)	oe, Print)			treet and Number or F	Rural Route Numbe	oro, MD 207				
m O - L		20a. Method of Disposition 1 ABurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State C	Place of Disponder, cemetery, cre hestnut	matory or othe Grove	Bapt.	Date 26/05	20c. Location - City or				
permit. Page Department of Important: If any injury or once.		Church Cemetery 2/26/U5 Esmont, Virginia 1. Signature of Funeral Service Licensee 22. Name and Address of Facility Thacker Brothers Funeral Home P.O. Box 185 Scottsville, VA 24590 3a. Part Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
Language be executed / Medical - Examiner buyaician and burial-transit sthe burial-transit	ai Examiner	shock, or heart failure. I only on Immediate Cause (Fural disease or condition resulting in death) Sequentially list conditions. Tany, backing to mirrediste cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (4r as a cons	equence of):	dwisce	dar Disa	se		Interval Between Onset and Death			
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 X Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒Ectopic preg ☐ Other (spec			23d. Date of de Month	Dlivery Day Year			
quires that n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death but not r	resulting in the I	underlying cau	se given in Part I.	23e. Did to	obacco use contribute to	o the cause of death?			
	Completed								utopsy findings availat completion of cause of s 2 No			
Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	lospital:	F1500		Other	eath (Check only o					
Jing After fune	-	1 XYes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time (Injury		. Injury at Work?		dence 6 □Other (Spanow injury occurred	эспу)			
or At after of Direction by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s	treet, factory,	office	28f. Location (S City or Tox	Street and Number or F vn, State)	tural Route Number,			
To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Medicai		sician: To the best of my liner: On the basis of exam and manner stated.									
To the vithir To the comp	W	29b. Signature and title of certifier Pamak Kouth	hay, ma		29c.	OCME		29d. Date signed (Mon February				
016		30. Name and address of person who co Pamela E. Southay		tem 23a) (Type		Penn Stre	not Polt	imore, Mary	1 01001			

ORIGINAL

Please Type or Print in Black Indeline Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23, Pt.II, 25 per ME, G841, U3/02/05 of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Joseph White Jr Date of Death
 Month **Physician** :29 PM 2005 0) /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Daltmore MU

r If Under 24 Hrs. 8 Date of Birth
Min. (Month, Day, Year) Wi Baltimore St. De ECOURS Û DA LTIMOR 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 2 F 220-84. -8502 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23e or 28a-f show treumetic event, the Modical Examinar must be notified at 1 Yes 2 No BALTIMORE Director MORE. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Completed by Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bar Tender Hotel Industries 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innert of Health and Mental ent: If Item 27 is marked o Joseph A. White Sr. Annie Hunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Annie D. Hunter-Mother 4001 Clarks Lane Apt 211, Balto, Md othert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 Department of Importent: If any injury or once. Woodlawn Cemetery 2/9/05 Baltimore Co, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIO Physician PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Tany, Lauring to Infraediate cause. Enter Underlying Cause (Disease or injury Examiner to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician Box 68760 Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □Ectopic pregnancy in the past 12 months? Month Dav Year signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use antibute to the cause of death? 2 1/No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No 2 2 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. p 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigate n Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, D0058207 MD 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 West Beltimore St. Bon Secours L. Kamsan MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 02 Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month cedent's Name (First, Middle, Last) Year **Physician** FEBRUIRY 2005 /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HOSpita more (In yrs. last birthday) Date of Birth Birthplace (State or Foreign Country) Funeral Days 1 XM 2□ F Months **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ir than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Race - American Indian, Black, White, etc. Was Decedent Eve Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **1** ☐ O þ ack 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Balto MD 212/8 or other . Method of Disposition 1 Description 2 ☐ Cremation Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonae Physician Edema Zymure /Medical -10 Due to (or as a consequence of). **Examiner** heart ear > Sequentially list conditions, if any loading 10 immedials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ler as a consequence of: Examine 3 attending physician and for use as the burial-transit Store Ren Due to (or as a conseq nce of): Division of Vital Records, P.O. Box 68760, 10 years Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for a in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2/2 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Unpatient 1 ☐ Yes 2 No 2 ER/Outpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? s after death. 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director: After it completely filled in by the funera Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and http of certifier 29c. License number 29d. Date signed (Month, Day, Year) LEV HEARUMON 2438946-FEBEUARY 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

Memoria

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Midd 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give 4b. City. Town, or Location of Death 4c. County of Death Examiner DSDICE HIMORE If Under 24 Hrs. 8. 7. Age (In yrs last birthday)
Yrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Director 72 hours efter death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28e-f show other treumatic event, the Madical Examinar must be notified at 1 Nes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Highway 12. Was Decedent Ever in U.S. Armed Porces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ 1 ☐ Yes 2 ☐ €0 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Sumame, Be Pages 1 and 2 should be finent of Health and Mental Feat; if item 27 is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tree once. 20b. Place of D BW160.MD 21206 Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause of pack line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner anding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2□No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 2 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation within 24 hours after death. To the Funerel Director: A 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature nd title of certifier DO058217 leter 18 30. Name and address of person who co. leted cause o death (Item 23a) (Type, Print) 1425 BOLTON ST

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2005

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and Me rtificate of Death		2000	06026
			Decedent's Name (First, Middle, Last)		2. Date of Death	9. No. UU	3. Time of Death
	Physici		Nadine D. Whittington			7 ^{Day} 2005	11:00 A _M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	1
			204 Juneberry Way Unit 1B	Glen Burnie		Anne Ar	ındel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day,	9 Birtl	pplace (State or Foreign
١.	Director		213-30-8831 1 M 2 F 72 Yrs.		Feb. 3,		yland
	and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary f sho	ρ	Maryland Anne Arundel Glen Burn	io			1 Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	h with	a D	204 Juneberry Way Unit 1B	21061		USA	
	deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - Ame	
98	or Ite	Y.F.	1 Never Married 2 Married 1 Tyes 2 No	1 ☐ Yes 2 🖫 No Specify:	ican, etc.,	Black, White Specify: Whi	•
8	within 72 hours after death with the Maryland ane. than "neture!, or items 23a or 28a-f show a Madical Examination in Items at	d by	3 Wildowed 4 A Divorced Year or Dates:				
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12	d within jiene. r than "	шо	Elementary/Secondary (0-12) College (1-4or 5+)	l Assistant		Maryland S	tate
b	Hyg Th	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, M	Government Maiden Sumame)	
<u>lar</u>	0 2 0 0	To B	J. Milton Koehnlein	Margaret	Emma	a Busch	
Maryland 21215-0036	and and sm			ng Address (Street and Number or Rural	Route Number,	City or Town, State, Z	ip Code)
	1 and 2 Health Iem 27 other tre		Cheryl A. Whittington (daughter) 163		a, Maryl	and 21122	
ore	jes 1 and of Healt if item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crei	matory or other place)		0c. Location - City or	own, State
Ë	Pages Iment of tent: If it jury or o		*4 □Donation 5 □Other (Specify) * Parkwood	Cemetery 3'04'	'05 B	saltimore,	Maryland
Baltimore,	permit. Pages. Department of H Importent: If ite any injury or of		Me Me	2. Name and Address of Facility CCULLY—POLYNIAK FUN 37 Fast Patapsco Av	ERAL HO	ME P.A.	Md 21225
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arres	st.	Approximate Interval Between
	- Enysician			erotic Hear	+ T) cougo	Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	erone premi		1 JEROE	
	Examiner		Sequentially list conditions, b.				
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	and trans	Examin	that initiated events				
8760,	te be executed ysician and e burial-transit		Due to (or as a consequence of);				
387	phys phys the	dicai	d				
9 xc	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decoded acceptable 23c. If yes, outcome of pregnancy			23d. Date of deli	ron.
Вох	death a atter	hysician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Month	Day Year
O.	at the de by the a stached	hysi	9 Unknown	, , , ,			
ς, Γ	es thai igned t be det	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	The law requires ite has been sign page 2 should be	eted t			1 ☐ Yes	s 2□No 3□Pro	bably 4 hknown
၁၁	aw re as be 2 sho	piet			24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Ä	The ate ha	Compl			autopsy performe	ed? death? ANo 1 ☐ Yes	2 No
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (<u> </u>		
of \	Physicien: this certific ral director,	2	1 Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatien	nt 3□ DOA Other: 4□ Nursing Home	e 5 X Residen	nce 6 Other (Spec	ify)
		on	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 27b. Time of Injury	Work?	3d. Describe how	v injury occurred	
isio	ten leat lor: the	icat	2 Accident investigation 3 Suicide 6 Could not be TBo Blood of Injury. At home for a state of the state of th	M 1 □ Yes 2 □ No	of 1 (O4		
Division	in the c	Certification:	determined 4 Homicide determined 28e. Place of Injury - At home, farm, strength building, etc. (Specify)	reet, factory, office	City or Town,	eet and Number or Rui State)	al Route Number,
_	urs urs erel	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, an	id due to the en-	seale) and manner	etated
	e Hos 24 h e Fur letely	edical	(Check only Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred	dat the time, dat	te and place, and due	to the cause(s)
	To the Hosl within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier Deputy	29c. License number	296	d. Date signed (Month	Day, Year)
/	1		// felliam Product mo	D000605	ge	3/1/5	
6	1		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)		-11	
-	1		William P. Jones, mo	695 Apmo	rica	210	35
	Sta Registr		30. Name and address of person who completed gause of death (Item 23a) (Type. 31. Date filed (Month, Day, Year) MAR 0 2 2005	Sparle			

HERMAN W. WRIGHT 05-01431 RKD

_			1 - State Registrar	aryland / Depa	artment of rtificate of		Mental Hygie	4000	06837
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Herman W	. W	<i>l</i> right		2. Date of Death Month FEBRUARY	Day Year 24, 2005	3. Time of Death 3:25P. M
	Examir		4a. Facility Name (If not institution, give street and number) 3810 BONVIEW AVE		BALTIM	.02.2		4c. County of Death	1-122
	Funeral Director		5. Social Security Number 217–56–7969 Usual Residence of Decedent 1 M	e (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye 5-6-52	9. Birth Cou	place (State or Foreign ntry) Md.
	Maryland a-f show	ctor	Md. 10b. County NA	10c. City, Town or Lo	cation Ltimore				10d. Inside City Limits
	th with the 23e or 26 unt be no	ai Dire	10e. Street and Number 3810 Bonview Ave.		10f. Zip Code 212	13	10g.	Citizen of What Cou USA	ntry?
9036	s 1 end 2 should be filed within 72 hours efter death with the Marylend I Heelth and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exagnana must be rediffed at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes Yill Yes, Give Year or Dates:	No I	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	od within 72 h giene. er than "natu , the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5	(Give	DO NOT use retire	during most of work	ang	Kind of Business/In	dustry
Maryland	2 should be filed withlic and Mental Hygiene. Is marked other than aumatic event, the Ms	To Be (17. Father's Name (<i>First, Middle, Last</i>) Levant	Wright		18. Mother's Nam Annie	e (First, Middle, Mai	den Sumame) Scott	
			19a. Informant's Name/Relationship (Type, Print) Stanley Wright Brot 20a. Method of Disposition 1 ☑ Print 2 □ Cremation 3 □ Removal from State	her 1328	8 Crofto sition (Name of natory or other pla	n Rd., Ba	ltimore, M	ty or Town, State, Zip id. 21239 Location - City or To ansdowne,	own, State
Baltimore,	permit. Page Department of Important: If any injury or once.		* 4 Donation 5 Other (Specify) 21. agnature of Funeral Service Licenses	1 22	Name and Addr March F.	ess of Facility	Balti	more, Md. North Ave.	21202
	Fnysician /Medical Examiner	e.	Sequentially list conditions	the death. Do not entre. Lin Si'V C Co a consequence of):			Cardin	MSCAlar	Approximate Interval Between Onset and Death
68760,	The law requires thet the death certificate be executed ste has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	a consequence of):					
.O. Box	et the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ery Day Year
s, P	w requires thet been signed b should be deta	by	Part II. Other significant conditions contributing to death by	perchole	nderlying cause gr	ven in Part I. UILL	23e. Did tobaco	co use contribute to the	ne cause of death?
Vital Record		Completed	status rugi trans	plant			24a. Was an autopsy performed	prior to cor	psy findings available inpletion of cause of
of	arth. arth. ar: After this ae funeral di	Certification; To Be	25. Was case referred to medical axaminer? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	y Year) 28b. Time of Injury	28c. Inju Wo M 1	ner: 4 - Nursing Ho	28d. Describe how in 28f. Location (Street	and Number or Rura	
D	To the Hospitel or Atte within 24 hours efter de To the Funeral Direct completely filled in by th		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred at the ti	me, date and place,	City or Town, St	ate)	atod
	To the H within 24 To the F complete	Medical	one) and manner sta 29b. Signature and title of certifier	100.	29c. Licens			and place, and due to Date signed (Month, I	
•	4		To find the 30. Name and address of person who completed cause of d			CME	FEB	RUARY 25,2	2005
•	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 2 2005	r's Signature	111 P	enn Street	Baltimo	re, Maryla	and 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician February: 25, 2005 Clister Belle Walker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ACINES Health cale timod **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 217-40-7030 Maryland February 23, 1943 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show id other than "natural", or items 23s or 28s-f show event, it a Medical Examinar must be notified at 1 Tes 2 No Directo **Arbutus** Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21227 U.S.A 1929 Grant Rd Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural, or item any injury or other traumatic event, It a Madical Examinarione. 1 Never Married 2 Married ☐Yes 2 XNo f Yes, Give 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Food Delivery Elementary/Secondary (0-12) College (1-4or 5+) Pizza Delivery Driver Я 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clister Belle Williams P Stanley Grabill Peugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 712 Wheatley Rd. North East, Maryland 21901 Son John Walker, Jr. Mr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Services, Inc. 03/01/2005 Sykesville, Maryland 21. Signetule of Funeral Service Licensee Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstancing Pulmously of Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 2 No 1 Yes Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 9 1 Yes 2 No 2 ER/Outpatient 3 DOA of After th funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: or Attending ision 1 Natural Injury 5 Pending 1 Yes 2 No investigation death 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

68760. ئە Record Vital X F H To the Funeral Director: To the Hospital Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Feblucky, 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimore: Malyland 21229 000 CINTON 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For Stete Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death y 28 2005 **Physician** February Doris Weisert 5:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1117 Harbor Way Churchton Anne Arundel 8. Date of Birth (Month, Day, Year) May 11, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) Months 1 □ M 27 F 577-26-4019 80 **Director** Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28e-f show ultrart-ust be notified at 10d. Inside City Limits 1 ☐ Yes 2√XNo MD Anne Arundel Shady Side Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4926 Rullman Road 20764 USA filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Who If Yes, Give Year or Dates: or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White þ **¾**CXWidowed 4 □ Divorced "naturei', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Business Officer Teamster Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiemt: If item 27 is marked other: Be Paul Lee Elliott Helen Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Hermann (Daughter) 1117 Harbor Way, Churchton, MD 20733 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department Importent: if eny injury o ment 4 □Donation 5 □ Other (Specify) Lincoln Cem. 03-04-2005 Brentwood, MD 21. Signature of Funeral 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 se, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a, Part1, Enter the disease. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final **Physician** neuma 3 disease or condition resulting in death) leavs /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) Year 2 No signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 Ho 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to autopsy performed certificate 2 No 1 Yes 2010 1 Tes the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 701 117965 dress of frson who completed cause of death (Item 23a) (Type, Print) 30. Name and as Huy Vetense 31. Date filed (Moon, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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	Completed by Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
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	ner	11. Marital Status	12. Was Decedent Ever in L	J.S. 13.	Was Decedent of H	ispanic Origin? (Spe	cify Yes or No-	14. Race -	American Indian,
	Ē	1 Never Married 2 Marne		1		n, Mexican, Puerto F	Rican, etc.)	Black,	White, etc.
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	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of workir ()	19		
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	d)	17. Father's Name (First, Middle, L.	ast)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
	ToB	DONZE MONK				EVA C	018		
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	edical Certification: To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the consect of the contribution of the	ancy al death 3 death 5 sulting in the underthin	DEctopic pregnancy Other (specify) It 3 DOA Other 28c. Injury Word 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26. Place of Death 26. Place of Death 27. 4 \(\text{Nursing Home} \) 28. 2 \(\text{No} \) 29. 2 \(\text{No} \) 20. 4 \(\text{Nursing Home} \) 20. 2 \(\text{No} \) 20. 4 \(\text{Nursing Home} \) 21. 2 \(\text{No} \) 22. 3 \(\text{No} \) 23. 4 \(\text{Nursing Home} \) 24. 2 \(\text{No} \) 25. 4 \(\text{No} \) 26. 2 \(\text{No} \) 27. 2 \(\text{No} \) 28. 3 \(\text{No} \) 29. 4 \(\text{No} \) 20. 4 \(\text{No} \) 20. 4 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 5 \(\text{No} \) 20. 6 \(\text{No} \) 20. 6 \(\text{No} \) 20. 6 \(\text{No} \) 20. 7 \(\t	23e. Did tob: 1 Yes 24a. Was an autopsy perform 1 Yes 2 (Check only one 95 Resider 8d. Describe how 8f. Location (Str. City or Town, and due to the car d at the time, da	Month acco use contributed account of the contri	of delivery Day Yea Ute to the cause of dea Probably 4 Unk The autopsy findings aver to completion of caustin? Yes 2 No (Specify) Or Rural Route Number or as stated. If due to the cause(s) Month, Day, Year)

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Freda Williams 05-01465 crn

l	100		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of l		lental Hy	/giene	05	068	342
	Physic	ian	1. Decedent's Name (First, Middle,	Last)				2. Date of D Month	Day	Year	3. Time o	of Death
	/Medi	čal,	FREDA WILLIA			4h Cihi Taua	and another of Dooth	Februa		2005	8:43	Р м
4	Examir	ner	4a. Facility Name (If not institution, Bon Secours Ho				or Location of Death Ltimore		4c. County	V/A		
	Funeral			3. Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of B		9. Birth	place (State	or Foreign
	Director		213-28-3848	1 □ M 2 🛣 F	76 Yrs.	Months Days	Hours Min.	5-3-1	928	MAR	ntry) YLAND	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside C	City Limits
	Marylan f show	ō	MD N/A		BALTIMO							s 2 No
	r 28a-	rec	10e. Street and Number		DALITMO	10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	th with	aiD	2301 DUKELAND	ST.		21216)		USA			
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Modical Exerting must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 1 Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes <i>o</i> r N Rican, etc.)		ce - Americk, White,		
21215-0036	ithin 72 ho ne. nan "natur Medical	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	edent's Usual Occup s kind of work done DO NOT use retire	during most of works	ing	16b. Kind of B	usiness/In	dustry	
	filed withi Hygiene. othar than ant, Ire M	S	-12- 17. Father's Name (First, Middle, L	-0-	CL	ERICAL	10 Mathada Nama	Cinn & Believelle	SOCIAL		RITY	
and	should be fi and Mental H s markad of umatic evan	To Be	ROBERT L. KEL				18. Mother's Name	A. YO		пө)		
Maryland	d 2 should be filed withir th and Mental Hygiene. ?7 Is marked othar than traumatic event, Ire M.	-	19a. Informant's Name/Relationshi CYNTHIA CLARK			-	and Number or Rura					
	s 1 and f Health item 27 other tr		20a. Method of Disposition	<u> </u>	20b. Place of Disp			Date	20c. Location			
Baltimore,	Parit L		1 ☐ Burial 2 ☐ Gremation 4 ☐ Donation B ☐ Other (Sp.	ecify)	GARRISON	FOREST VE	TERANS 3-	4-2005	OWINGS	MILLS	S, MD.	
Ba	permit. Departn Imports any inju		21. Signat re al Funeral Service L	censee JONA HAN			ess of Facility PHI MONROE S					1217
	Physician		23a. Part I Enter the disease, or o shock or heart failure. List o Immediate Cause (Final disease or condition	omplications that caused half one cause on each line a.	the death. Do not enter	ter the mode of dying affective affe	scleroti	c Care	arrest, Li OVASCA	ukr	Approxima Interval Be Onset and	tween
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		d1.	ila se				
S.	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	a consequence of):							
8760,	cate be executed oblysician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a	a consequence of):							
.O. Box 68	eath certifi attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	у			te of delive	,	Year
<u>α</u>	w requires that the dispense that the dispension of the should be detached		Part II. Other significent condition Diobe for m	s contributing to death by	ut not resulting in the u	inderlying cause give	ven in Part I.		tobacco use cont	ribute to th		death? Unknown
Vital Records,	w requ	Completed by	Chronic a	Icohola	buse			24a. Was	an 24b. V	Were auto	psy findings	available
Re	The lay te has age 2:	шо						auto perfo	psy prmed?	prior to co death?	mpletion of c	ause of
ital	yslcian: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?				26. Place of Death	, ,		103		
of V	Physic this ce al direc	10	1 XX es 2□No	Hospital: 1 ☐ Inpatie	nt 2 XER/Outpatie	nt 3□ DOA Oth	ner: 4 ☐ Nursing Hor	ne 5□Resi	dence 6 □Oth	er (Specif	y)	
ion o	ath. rr: After t	Certification;	27. Manner of Death 1 Avatural 5 Pending 2 Accident investiga		y Year) 28b. Time of Injury	Wor	yat rk? Yes 2 □ No	28d. Describe	how injury occurr	red		
Division	after de after de Diracto d in by th	ertific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farm, st . (Specify)	reet, factory, office	2	28f. Location (City or To	Street and Numb wn, State)	er or Rura	I Route Num	ber,
	To the Mospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Cartifying (Check only one)	Physician: To the best of caminar: On the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, a ppinion, death occurre	and due to the ed at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s	5)
	, ,, ,	Me	29b. Signature and title of certifier	ulal,	Ali-	29c. Licens	e number		29d. Date signed February			
	3		30. Name and address of person w	no completed cause of de	eath (Item 23a) (Type,	Print) 111 Pe	enn Street					.201
	Sta		31. Date filed (Month, Day, Year)	4	r's Signature							
DH	Registi MH 17 Rev 1/2		MAR 0	2 2005	ever &	Courte		·				
				-	ORIGINA	AL						

		For State Registrer 1. Decedent's Name (First, Middle, La	st)		ertificat	e of l	Death		2. Date of De	Reg. No.	CUU	3. Time of Death
Physici		Paul S. Walmsley	si)						Month	Day	1005	ATITE A
/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or	r Location o	of Death	1-Bisho		nty of Death	
Examin		GOOD SAMARI	TAN HOS	PITAL	1	BAL	TIM	RE	•		NIA	?
Funeral		5. Social Security Number 6. S		e (In yrs. last birtho	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit (Month, Da 7/22/1	rth ay, Year)	9. Birth	nplace (State or Foreign
Director		213-16-9562 Usual Residence of Decedent		86 Yrs					7/22/1	918	Ma	aryland
yland		10a. State 10b. County		10c. City, Town o	Location							10d. Inside City Limits
e Mar He-fsl	ctor	MD N/A		Baltin	ore							1 ☐Yes 2 ☐ No
or 28	Dire	10e. Street and Number 3809 White Avenue			10f. Zij	Code	0.0			10g. Citizen		untry?
ns 23e	Funerai Director	11. Marital Status	12. Was Decedent 8	Ever in U.S.	3. Was Dece	212		igin? (Sp	ecify Yes or No	U.S.		rican Indian,
n /2 nours after deetn with the Maryland "naturel", or items 23e or 28e-f show suical Exacitor must be nutitled at	by Fun	1 Never Married 2 X Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:	lo	If Yes, spe		n, Mexicar Specify:		ecify Yes or No Rican, etc.)	Spe-	Black, White	
ature G. E.	ted	15. Decedent's E	ducation	16a. D	cedent's Usu	al Occupa	ation			16b. Kind of	Business/I	ndustry
Hygiene. Hygiene. Sther than "nai	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	*)	ive kind of wo				ing			
other th		17. Father's Name (First, Middle, Last,	4	E]	ectron	ic B			- /Fi A & 41-d-11-		Emp1c	yed
ed of	Be	James Carroll Wal							e (First, Middle ne Haup		iame)	
ls mark eumeti	ဥ	19a. Informant's Name/Relationship (19b. M	ailing Address				al Route Numb		vn, State, Z	ip Code)
C N 5		Alma Walmsley/Wi	Ēe	380	9 Whit	e Av	enue	Balt	imore,	Maryla	and 21	.206
If item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D cemetery,	sposition (National National N	me of other plac	ee)		Date	20c. Locatio	n - City or T	Town, State
tent:		' 4 ☐ Donation 5 ☐ Other (Specif	y)	Parkwo				2/26		Baltin	nore,	Maryland
Impor any in once.		21. Signature of Funeral Service Licer	1588	\rightarrow	22. Name at	nd Addres	ss of Facilit	y Mil	ler-Di _l altimo:	ppel Fu	neral	Home Inc.
		23a. Part F. Enter the disease, or com	ploations hat caused	the death. Do not							. утапо	Approximate
sician		shock, or heart failure. List only Immediate Cause (Final	one cause on the little	STOLV								Onset and Death
edical		disease or condition resulting in death)	a. Du to (r as a	a consequence of):								30 MIR
aminer		Sequentially list conditions.	b. GRAD	YARRH	ITHO	ZIA	0					4 HOURS
sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Du k (or as	consequence of	-0 4	-	UR	بر				4 HOURS
lysician and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):	R /	14/2	-010	2				UNYS
ysiciar ie buri	cail		d									
attending phy I for use as the	Med	IF FEMALE:									-	
attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 □Ectopic p 5 □ Other (se						Date of deliv Month	very Day Year
detached f	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown	time or ogati	2 □ Other (St	ecity)						
igned b	by Pt	Part II. Other significant conditions of			underlying o	ause give	en in Part I.		23e. Did t	obacco use co	ontribute to	the cause of death?
been sig should b	ed b	PULMONI	ory ED	EMA					1 🗀 '	Yes 2□No	3 ☐ Pro	bably 4 Unknown
as be	ompieted								24a. Was		o. Were aut	opsy findings available ompletion of cause of
s certificate has b irector, page 2 s	Con									rmed? 2 X No	death? 1 ☐ Yes	
director,	Be	25. Was case referred to medical examiner?	Hospital:	V		Othe	ar		(Check only o			
After this funeral dir	: To	1 ☐ Yes 2 No 27. Magner of Death	28a. Date of Injur	y 28b. Tim	_	28c. Injury	at Nu		me 5 Residente R			ify)
: Arre a fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		Work	<br Yes 2 🔲!					
Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, farm	street, factor	y, office			28f. Location (S	Street and Nur.	nber or Rur	al Route Number,
To the Funerel Direct completely filled in by								l.				
Fune tely fil	edicai	(Check only 2 Medical Exer	ysicien: To the best of	examination and/o	ath occurred investigation	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and r date and place	manner as s e, and due t	stated. to the cause(s)
To the	Med	29b. Signature and title of certifier	and manner sta	ted.		c. License		<u> </u>		29d. Date sign		
- 8)			+	150	754	6		2/1	3/1	5
17		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	e, Print)	ואחו	Loc	HI	RAVEA	Bou	LEV	ARD
		TERESA MU	NS, DO			3.44	TIM	ORE	- M	9 RYLA	AND	21239
Sta		31. Date filed (Month, Day, Year)	32. Registra	ır's Signature					/			
Registr		MAD 09	2005	to the	local	,						
IH 17 Rev 1/20	001	MAR UZ	LUUD Street	ORIGI	VAL.							

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artmen rtificat					jiene _{eg. No.} 0 ()5	06844
			1. Decedent's Name (First, Middle, Last,)						2. Date of Dea	th		3. Time of Death
	Physicia		Inez Auro	ra	Aldrighett	- 4				Month	Day	Year	0 - 20 - M
}	/Medic Examin		4a. Facility Name (If not institution, give		ATULTSHELL		Town, or	Location of	of Death	Februar	4c. County	of Death	9:30p
			14409 Marine Dri	ve		Si	lvei	Spr	ino		Mon	tgome	227
	Funeral		5. Social Security Number 6. Set	x 7. Ag	e (In yrs. last birthday)	If Under Months	1 Year Days	Spr If Under Hours	24 Hrs. Min.	8. Date of Birth		9. Birth	place (State or Foreign
	Director		084 09 6959]M 2√x F	85 Yrs.	Months	Duyo	Tiou.o		July 7,	1919	Ne	ew York
	pu 🖈	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	nastion							10d. Inside City Limits
	aryia shor	2											1 Yes No
	Ne M	Director	Maryland Montgom	iery	Silver Sp		<u> </u>						
	hours after death with the Maryland turel', or items 23a or 28e-f show al Examiner must be mulliku at		10e. Street and Number			10f. Zip	Code			'	0g. Citizen of	What Cou	intry?
	s 23	Funerai	14409 Marine Drive	12. Was Decedent	Event in 11 C 42	1W D	2090		=1-2 (C-		US		can Indian,
	item item	'n	11. Marital Status 1 Never Married	Armed Forces?		If Yes, spec	ent of H	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		ck, White	
38	irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	-0	1 🗆 Yes	2X No	Specify:			Specif	y: Wi	nite
ğ	I within 72 hours after death with the Marylar jiene	per	15. Decedent's Edu	ıcation	16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of B	usiness/lr	ndustry
15	within 72 ene. than "ne he Wedic	pie	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5	(Give	kind of wo DO NOT u	rk done d	during mos	t of work	ing			,
\sim	d with	Completed	12	College (1-40)		memak	er				0	wn Ho	ome
Þ	e filed al Hygia other vent, II	ВеС	17. Father's Name (First, Middle, Last)					18. Mothe	er's Nam	e (First, Middle,	Maiden Surnai	ne)	
<u>a</u>	Aenta Aenta rked	To E	Antonio Sutera					Vir	gini	a DeOte	ris		
Maryland	s ma		19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Number	, City or Town	State, Zi	p Code)
Σ	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, Once.		Nerino Vito Aldrig	hetti/Hus	sband 1440)9 Mar	ine	Drive	e Si	lver Spr	ing, M	arv1a	and20904
Baltimore,	of He		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Nar.	ne of		- 17-1	Date	20c. Location	City or T	own, State
Ĕ	Pages nent of ant: If II		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Fort Line	oln (rema	tory	2/1	6/2005 F	rentwo	od, N	Maryland
alt	permit. Departr Imports any inju		21. Signature of Funeral Service Licens	999	/								Home20904
œ	88 188		Kuna	Noul	- 1	1800	New	Hamp	shir	e Avenue	Silve	r Spi	ring, MD
			23a. Part1. Enter the disease, or compostock or heart failure. List only o	lications that caused	the death. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition										Onset and Death
	/Medical		resulting in death)	a. Lung C Due to (or as	ancer a consequence of):								
	Examiner		0	b									
	_ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):								
	cutec	Examiner	that initiated events	c									
0	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):								
8760,	0 0	icai	(d									
39	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:									1.	
Вох	th ce tendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pr	egnancy					ite of deliv	*
). E	e dea he at	sici	1 ☐ Yes 2♣ No	4□Pregnant a 9□Unknown	t time of death 5[Other (sp	ecify)				IVI	onth	Day Year
P.0	that the de led by the detached	Phy	9 Unknown							00 0111			
Ś	es ope	by	Part II. Other significant conditions co	intributing to death t	out not resulting in the t	underlying c	ause givi	en in Part I	•		_		the cause of death?
Records,	w requir been si should	Completed								1 L Y	es 2 No	3 Pro	bably 4 hknown
ec	e law has b	pje								24a. Was a autop:	sy	Were aut	opsy findings available ompletion of cause of
<u> </u>		Con								perfor 1 ☐ Yes	med? 2 No	death? 1 🗌 Yes	2□ No
Vital	Physiclan: r this certificatal director,	Be	25. Was case referred to medical examiner?						e of Deat	n (Check only or	10)		
of \	Physi this c al dire	2	1 Yes 2 No		ent 2 ER/Outpatie			4 🗀 141	ursing Ho	me 5 Resid			ify)
	ding P. h. After i funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	iry Year) 28b. Time o		8c. Injun Worl			28d. Describe h	ow injury occur	red	
Sic	Attending r death. sctor: After y the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 🗌	No				
Division	for Attendated after death Director:	Certification:	4 Homicide determined	28e. Place of in	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory	, office			28f. Location (S City or Tow		ber or Rui	ral Route Number,
	urs a		20 0 - 17 - 17 - 17 - 17 - 17 - 17 - 17 -										
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a, Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	iner: On the basis of	of my knowledge, dea of examination and/or in	th occurred rvestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the c red at the time, c	ause(s) and m late and place,	anner as : and due !	stated. to the cause(s)
	thin 2 the the mple	Mec	29b. Signature and title of certifier	and manner st	ared.	290	License	e number		2	29d. Date signe	d (Month	Day Year)
	To Your		1/1/1/1	1 :44	.~	2.00	C >	10	2				
	12		20 Name and	1	(1)	D-1 "	> 5	77	/		Februa	ry 10	2005
	7		30. Name and address of person who c				7	277	36	11	20050		
	Sta	oto-	John Wallmark 970 31. Date filed (Month, Day, Year)	7/ Med1ca 32. ® aist	L Center Dr	ive K	ockv	TILLE	, Ma	ryland	20852		
	Sie Registi		FEB 142	005	rar's Signature	MILLE	,						

			1 - For State Registrar	State of Maryland		artment of H		nd Mer		iene	05	068	45
			1. Decedent's Name (First, Middle, Las)					Date of Deat Month	h Day	Year	3. Time of C)eath
	Physici /Medio		Almeda 1	Bowen Anderson					bruary			15:14	М
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	Death		4c. County	of Death		
			Southern Maryland			Clinton				Prince	e Ge	orge's	
н	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I ☐ M 2団 F 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Dete of Birth (Month, Day, ne 12,	Year)	Cou	place (State or intry)	
þ.	Director		246-30-3248 Usuel Residence of Decedent	01	115.			μu	ne 12,	1923	NIIII	iámstow	a NC
	land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation	-					10d. Inside City	Limits
	Many 	tot	MD Prince G	orge's Su	itland							1 Yes	2 🗌 No
	r 288	rec	10e. Street and Number			10f. Zip Code		7	11	Og. Citizen of \	What Cou	intry?	
	h with	Funeral Director	5412 Manchester I)r.		20746			U	nited S	State	es	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	in? (Specify	Yes or No-			ican Indian,	
9	or Its	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No	1	1 □ Yes 2120MNo	Specify:	T detto Tilce	ari, etc./	ł	ck, White, y: Bla		
ğ	urat',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:						Specify		4CK	
Ŋ	filed within 72 hours after death with the Maryland Hygiene. Sther than "natural", or lams 23a or 28a-f ehow sht, the Medical Examiner must be motified at	Completed	15. Decedent's Ed (Specify only highest grad	ication le completed)	(Give	tent's Usual Occupa kind of work done of DO NOT use retired	turing most	of working		16b. Kind of B	usiness/Ir	ndustry	
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an	d be sortal ced o	To Be	Eddie Bowen				Lill		Land		,		
Maryland 21215-0036	should be and Mental marked o umatic eve	Ĕ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a				City or Town,	State, Zi	p Code)	
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 is marked other than "naturat", or Itams 23e or 28e-f show other traumatic event, the Medical Exercitive must be colified at		Kaifa Anderson-Hai	ll / Daughter	5	Downing					-		
ē,	s 1 a f Hez itam othe		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place	a)	Date		20c. Location -	City or T	own, Stete	
altimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is eny injury or other tra ance.		1 ☑Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-	1n Cemete		/15/20	005	Brentwo	ood	MD	
a	permit. Departminitude of the contract of the		21. Signature of Funeral Service Licen:			Name and Addres		one Fi	uneral	Ното			
m	88 5 8		Xaloxa TI	1 Xarro		2617 Penn	Ave	SE Was	shingt	on DC 2	20020)	
F			23a. Pert1. Enter the disease, or composition of the shock, or heart failure. List only of	lications that caused the death	n. Do not ent	er the mode of dying	g, such as c	ardiac or re	spiratory arre	ıst,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	Corunary	ACT	ery ()1	500)	0				Onset and De	ath
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		<i>J</i>						
	Examiner	_	Sequentially list conditions, if any, reading to immediate	b									
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	иепсе от):								
	and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):								_
8760	death certificate be executed e attending physician and of for use as the burial-transit	ajE		,	,								
687	ficate physics the	edicai		0.									
Box	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Da	te of deliv	erv	
m	death e atte d for	icia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)					onth	Day Ye	ar
0.	the by the lacke	Physician/Me	9 Unknown	9□ Unknown									
	The law requires that the de ite has been signed by the a rage 2 should be detached f	by P	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.		23e. Did tob	acco use cont	ribute to t	he cause of dea	ath?
Srd	w require been si should b	per						-	1 ☐ Ye	s 2 No	3 Prot	bably 4 □Un	known
ecc	e law r has be	pie							24a. Was an	246.	Nere auto	opsy findings av	/ailable #
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/ita	cien: ertific	Be (25. Was case referred to medical examiner?					of Death (C)	hack only one	9)			
5	Physic this c	၉	1 Tes 2 No		ER/Outpatien		4 L Nurs			nce 6 Oth		fy)	
n C	ling F	jon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work			Describe ho	w injury occurr	ed		
Division of	ten leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ma fam etc		res 2 □ N		Location (Str	ant and Numb	ar or Rue	al Route Numbe	0.5
<u>≥</u>	after Dirak Jin by	Certification:	4 Homicide determined	building, etc. (Specify	()	eet, ractory, office			City or Town		en on more	ar nodla rvanibe	31,
	Hospita 4 hours Funeral tely filled		29a. Certifier 1 X Certifying Phy	rsician To the best of my know	wledge, death	occurred at the tim	e. date and	place, and	due to the ca	use(s) and ma	nner as s	stated.	
	To the Hospitat or At within 24 hours after of To the Funeral Diract completely filled in by	edical	(Check only 2 Medical Exam	iner: On the basis of examinat and manner stated.	tion and/or inv	vestigation, in my op	oinion, death	occurred a	t the time, da	te and place,	and due to	o the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and ittle to certifier	/		29c. License	number		29	d. Date signed	1 (Month,	Day, Year)	
			1410			11)00	1394	28		2-1	1-0	15	
2	(5)		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type.		LLr	0 -		01 7		n.02	122
			31. Date filed (Month, Day, Year)	→ Registrar's Signal	US	Jurra	111	ILUG	10 (ilar	~ / Y	N. D.	075)
	Sta Registi		FFR 1 6 2005		ha	RI							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 13, 2005 4:30 p Anderson Ruth Wilhelmina /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laure1 Laurel Regional Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Under 24 Hrs. 18. Date of Birth Month, Day, Unity 2, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗗 F Maryland Yrs. Director 577-01-5997 85 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show other traumatic avant, the Medical Examinar must be notified at 1X Yes 2 No Prince George's College Park Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 9718 Wichita Avenue 20740 U.S.A. or itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is markad othar than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Teresa Veronica Blake William J. Quinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Anderson - Son 3168 Eutaw Forest Drive, Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o once. 1 XBurial 2 □ Cremation 3 □ Removal from State Holy Trinity Cemetery | Feb. 17, 2005 Bowie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service kicent 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 23a. Pint1 Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease if condition resulting in death) Aspiration Pneumonia Pnysician /Medical Du to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. Renal Insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Spinal Stenosis 24a. Was an autopsy performed? certificete 2 🗆 No 1 Yes 2X No 1 Tes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 I No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c, Injury at Work? After 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide ö To tha Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 2114/05 Berzingi / ML 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Honor parking suct los Grancelt 3ev2,491 FEB 1 6 2005 . Registrar's Signature 31. Date filed (Month. State Registrar

			_ FOI	Department of Health and M Certificate of Death	, ,	ne No.2005	06847
Ī	Physici		1. Decedent's Name (First, Middle, Last) Leticia M. Ago	onoy	2. Date of Death Month	Pay Year 14, 2005	3. Time of Death 2:28P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
N.			Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bird	Clinton thday) If Under 1 Year If Under 24 Hrs.		Prince Ge	
i,	Funeral Director		267-89-4913 ¹□M ¾□xfx 60	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yel 08/23/19	ar) 9. Birth Cou 44 Phi	plece (State or Foreign Intry) lippines
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
	Mary P-f eh	ţ	Maryland Prince George's Ft. W	Vashington			1 ☐ Yes 🏞 🔀 No
	or 28	Directo	10e. Street and Number	10f. Zip Code		Citizen of What Cou	
	eath w	era	104 E1 Catnino Way 11. Marital Status 12. Was Decedent Ever in U.S.	20744		nilippine:	
136	72 hours after death with the Maryland "natural, or iteme 23a or 28a-f ehow colcal Examinat must be notilied at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 □ No If Yes, Give ** Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White	
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פר	m = 0 5	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
ylar		ToE	Lope Manuel		cia Berna		
Maryland	d 2 shoth and 7 is m			. Mailing Address (Street and Number or Run			,
	s 1 and 2 should of Health and Mer item 27 is marke other treumatic		E. Rodger Agonoy / Husband 1 20a. Method of Disposition 20b. Place of	O4 El Camino Way, Ft. Disposition (Name of y, crematory or other place)		On, Mary La Location - City or T	
Ē	Pages nent of ant: If it any or o		I Burial 2 Ki Cremation 3 Hemoval from State		/2005 Edg	rewater.	Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility George P 6160 Oxon Hill Roa	. Kalas Fu	meral Ho	ne P.A.
į			23a. Part1 Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.			ii, Maryia	Approximate Interval Between
	Physician			andral Infanction			Onset and Death
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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9		/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	0.04
P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	3 Dectopic pregnancy 5 Other (specify)		Month	Day Year
	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions contributing to death but not resulting in End Stage Rend Ossens Herro chaly a d	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	the cause of death?
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al Re	: The law cate has I	Completed			autopsy performed 1 Yes 2 🖃	prior to co	empletion of cause of
X	sician: The certificate	o Be	25. Was case referred to medical examiner?	Other	h (Check only one)		
on of	ding Phys h. After this funeral di	-	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	tpatient 3 DOA 4 Indising Ho	ome 5 Residence 28d. Describe how in		fy)
Division of Vital Records,	or Atten after deal Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fail building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as s and place, and due t	stated. o the cause(s)
	To the To the Comple	Me	29b. Signature and title of continer	29c. License number	29d. l	Date signed (Month,	Day, Year)
A			Nam mi	00055120	F	\$ 15,20	05
K	(6)		30. Name and address of person who completed cause of death (Item 23a) (huh AROL Palmur hi) 13 is jorkan Are	Type. Print) my JE Just 200 Wash	no La AC >	0132	
· ·	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature FEB 1 7 2005	me JE Juk 210 Wash	1		
	Registr	वा	The second second	MBM/5 J			

		1 - For Stete Registrar	State of Marylan	_	artment of F			Reg. No. Z	005	0.5	8 L 9
Physic /Med Exam	ical	Decedent's Name (First, Middle, Last George S. Aa. Facility Name (If not institution, give	August		4b. City, Town, o	r Location of De	2. Date of Dea Month FEBRUAI	RY 12,	Year 2005 unty of Death	3. Time of 4:09	A M
Funera Directo		019-03-4046	ex 7. Age (In yrs.	last birthday) 35 Yrs.	SILVER S If Under 1 Year Months Days			h y, Year)	Cour	place (State o	•
th the Maryland or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOM 10e. Street and Number		y, Town or Lo				10g. Citizen	of What Cour	10d. Inside Cit 1 X Yes ntry?	-
ING 21215-0036 be filed within 72 hours after death with the Maryland tial Hygiene. I other than "natural; or flams 23a or 28a-f show avent, the Medical Examinar must be notified at	by Funeral	9225 COLESVILLE R	OAD 12. Was Decedent Ever in U Amped Forces? 1 ÄYes 2 □ No ARI If Yes, Give Year or Dates: WWI	1Y	2091 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		(Specify Yes or No- erto Rican, etc.)	14.	Race - Americ Black, White, ecity: WH		
21215-0036 ad within 72 hours af rgiene. ier then "natural", or t, the Medical Exam	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	College (1-4or 5+) 5+	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of w		DENTI		dustry	
	a)	17. Father's Name (First, Middle, Last) MORRIS 19a. Informant's Name/Relationship (AUGUST	19b. Mailir	ng Address (Street	JENNIE	ame (First, Middle, Rural Route Numbe	BL	оск	Code)	
Baltimore, Marylan permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic avence.	>	LISSA AUGUST/DAUG	Removal from State	Place of Dispo emetery, crei	sition (Name of matory or other plac	:8)	SILVER SI	20c. Locati	ion - City or To	own, State	
Baltin permit. P Departme Importan any injury		1. Signature of Funeral Service Licer 1. Signature of Funeral Service Licer 1. Manda	udewig	D 22	ANZANSKY- 170 ROCK	ss of Facility -GOLDBER /ILLE PI	/15/2005 G MEMORIA KE, ROCKV	AL CHA			JINIA
Physician /Medica		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cap do the deat one cause on each line. a. CARDIAC ARRE Due to (or as a conseq	ST	ter the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Bety Onset and D	waen
. Box 68760, death certificate be executed e attending physician and id for use as the burial-transit	icai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. MYOCARDIAL I Due to or as a conseq c. Due to (or as a conseq d.	NFARCT	ION						
P.O. BOX 68 tal the death certifice by the attending presence of the control of t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d.	Date of delive Month		'ear
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f Vital Records, ysician: The law requires t is certificate has been signe director, page 2 should be	Completed						1 ☐ Yes	sy med? 2∑No	death?	psy findings ampletion of ca	ivailable iuse of
OD O ding Ph h. After th funeral	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c, Injun Worl	er: 4 🗆 Nursing	eath (Check only of Home 5 Residence 128d. Describe h	lence 6 🗆		<i>ı</i>)	
Division To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specif	y)			28f. Location (S City or Ton	m, State))e <i>r</i> ,
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2 2 5	2	29b. Signature and title of certifier	JB co		29c. Licenson D21931				gned (Month, i		
V -		30. Name and address of person who STEVEN A. BURGER, 31. Date filed (Month, Day, Year)	M.D., 2101 ME	DICAL	PARK DR.	#211,	SILVER SE	RING,	MD 209	902	
S Regis	tate trar	FEB 1 5 20	32 Registrar's Signa	K AN	we						

			For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	artment of I tificate of	Health a Death	and Me		jiene eg. No.	05	06849
	Division		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici: /Medic		Andrea			- 1	Adam	15 1	ESTURY		202	15:00 PM
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, o				4c. Cou	nty of Death	
			Johns Hopkins 5. Social Security Number 6. Sex		. last birthday)	Baltin If Under 1 Year		24 Hrs. 1			9 Rinth	place (State or Foreign
	Funeral Director			^{M 2} F 59	Yrs.	Months Days		Min.	B. Date of Birth (Month, Day 04/02/1	(Year)	Texa	ntry)
	p		Usual Residence of Decedent						047 027 1			
	shov	7.	10a. State 10b. County		ity, Town or Lo	cation						10d. Inside City Limits 1
	the N	ect	Maryland Prince Geo	orges Bo	owie	10f. Zip Code				Ing Citizen	of What Cou	
	3a or		12300 Round Tree La	ne		20715				USA	or •••••••	y.
	death	nera		2. Was Decedent Ever in t Armed Forces?	J.S. 13. \	Was Decedent of I	Hispanic Orig	gin? (Spec	ify Yes or No-	14. F	ace - Ameri	
98	or ite	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		ires, specily Cub I⊡ Yes 2 🛣 No		, ruello n	ican, etc.)		Black, White,	
Ö	within 72 hours after death with the Marylend ene. than "natural", or Items 23a or 28e-f show the Medical Examinet must be notified at	q pe	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	162 Dagge	Iontia I Isual Ossu	nation				Whi	
5	in 72 in al	Completed	(Specify only highest grade	completed)	(Give	lent's Usual Occuj kind of work done DO NOT use retire	during most ad)	t of working	9	16b. Kind of	Business/In	idustry
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pu	al Hyg	36	17. Father's Name (First, Middle, Last)				18. Mother	r's Name ((First, Middle,			
yla	Ment Ment arkec	To	Percy Guy Adams				Pauli					
Maryland 21215-0036	12 sh h and 7 le m treum		19a. Informant's Name/Relationship (Type Richard Adams/ Br	•		g Address (Street					vn, State, Zij	o Code)
-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importent: if Itam 27 is marked other than "natural", or items 23a or 28e-f show any figury or other treumatic event, the Macical Examiner must be notified an once.		20a. Method of Disposition		Place of Dispo	ox 1287 T sition (Name of	1	ISV11. Da			n - City or To	own, State
Baltimore,	bages ent of ht: If II		1 ☐ Burial 2 [XCremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State		natory or other pla ematory	1	2/10	/2005			
alti	mit. F partme sorter lojur		21. Signature of Funeral Service Licenses			. Name and Addre	ess of Facility	y Robe	ert E.	Evans	Funer	al Home
ä	Departing Department of the partment of the pa		alla Shere	- Meos	44 16	6000 Anna	apolis	Road	d Bowie	, Mary	land	20715
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dea cause on each line.	ith. Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
A	Prysician		Immediate Cause (Final disease or condition	Scosis	5							Onset and Death ろ ひにすら
П	/Medical Examiner		resulting in death)	Due to (or as a conse								
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		illure					-	7 cleys
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ó	e exec en an rrial-tr	Exe	resulting in death) Last	Due to (or as a conse	quence of):							
8760,	the death certificate be executed y the attending physicien and iched for use as the buriat-transit	dical	d.									
9	leath certific attending p	/Me	IF FEMALE:	c. If yes, outcome of pregr	nancy							
Вох	atten atten I for u	clan	in the past 12 months?	1☐Live birth 2☐Fet	al death 3	Ectopic pregnanc Other (specify) _	У				Date of delive Month	ery Day Year
P.O.	that the di ed by the detached	hysl	1 Yes 2 No 9 Unknown	9□ Unknown								
		by Physician/Me	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.		23e. Did to	./		he cause of death?
ord	w require been signature should b	ted							1 🗆 Yı	es 21/21/40	3 Prot	pably 4 Dunknown
Vital Records,	a 2 C1	Completed							24a. Was a autops	SV	prior to co	ppsy findings available impletion of cause of
alF										2/No	death?	2 No
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Nnpatient 2 [☐ ER/Outpatien	t 3 DOA Oth			Check only or e 5 ☐ Reside		Dah (C	
of		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		ry at	28	e 5 🗆 Reside 3d. Describe h	ow injury occ	ourred	у)
ion	Attending r death. ector: After by the fune	atlo	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		Yes 2 1	No				
Division of	- 0 -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28	Bf. Location (Si City or Town		mber or Rura	al Route Number,
	pitel o		29a. Certifier 1 Certifying Physi	ninn. To the book of my len	souladas dasti			d ala aa . aa				
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only one)	cian: To the best of my kr er: On the basis of examin and manner stated.	ation and/or inv	estigation, in my	me, date and opinion, deat	th occurred	d at the time, d	ause(s) and ate and plac	manner as s e, and due to	o the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens	se number		2	9d. Date sig	ned (Month,	Day, Year)
1			Helindean	el		RES	-00	C	F	cb vuc	44 9	2005
			30. Name and address of person who con 30HWS HOPKINS HOSP	npleted cause of death (Ite	om 23a) (Type,	Print) HECT	~A 1	CASS	AHUN			71287
	-0		21 Data filed (Month Day Voor)	22 Danie Arla Ciar		worfe	Stre	4, B	citina	ve_	mor	ylend
	Sta Registr		FEB 11	2005	1	South						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 2:37 P **Physician** 6, 2005 BAKER ROSE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY POTOMAC POTOMAC MANOR CARE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F Yrs FEB. 26, 1918 NEW YORK 86 054-09-6589 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County rthan "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director DAMASCUS MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20872 10512 NICKELBY WAY death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No altimore, Maryland 21215-0036 WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within in and Mentat Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME 10 HOUSEWIFE permit. Pages 1 and 2 should be filled with Dapartment of Health and Mental Hygler important: if item 27 is marked other the any injury or, ther traumatic event, list page. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FANNIE 0 ISAAC GREENBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10512 NICKELBY WAY, DAMASCUS, MD 20872 BRIAN BAKER/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X RemovaLfrom State BETH ISRAEL CEMETERY 02/09/2005 WOODBRIDGE, NEW JERSEY ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Supres Li DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Jake 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED ALZHEIMERS DEMENTIA Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached 9 Unknown o signed by Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 X No 3 ☐ Probably 4 ☐ Unknown SEVERE OSTEOPOROSIS Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ATRIAL FIBRILLATION autopsy performed? has 2 XNo 1 ☐ Yes certificate ATHEROSCLEROSIS 26. Place of Death (Check only one) the funeral director. Be 25. Was case referred to medical examiner? Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 💢 No Certification; To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 T Homicide within 24 hours a To the Funeral L (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 31 FEBRUARY 7, 2005 Albiol, M.D ddress of person who completed cause of death (Item 23a) (Type, Print) Loreto

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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		•	1 - State Registrar	State of M	laryland / [epartme <i>Certifica</i>			nd Me		ene	5 06	851
			Decedent's Name (First, Middle, Last,	1					2	. Date of Death			e of Death
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	Examin		4a. Facility Name (If not institution, give	street and number,)	4b. Cit	y, Town, or	Location of	f Death		4c. County of E	Death	
			Genesis Eldercar	e-Layhill	Center		Silve	er Spr			Mo	ntgomei	У
	Funeral Director		5. Social Security Number 6. Se 134-14-2549	7. A	ge (In yrs. last birt 79	Yrs. If Und Month	er 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, ept. 2]	rear)	Birthplace (Sta Country) New Y	
	pui		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d Incid	e City Limits
	Aaryli reho	5											es 2 ⊒XNo
	28a-	Director	Maryland Monto	omery	Rockv		ip Code			10	g. Citizen of What	t Country?	
	3a or	<u>a</u>	4400 Bestor Driv	·e			208	353			•	SA	
	death	Funeral	11. Maritat Status	12. Was Decedent		13. Was Dec	edent of Hi	spanic Orig	in? (Specif	y Yes or No- can, etc.)	14. Race - A	American India),
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or itama 23e or 28e-f ehow event, the Medical Examinar must be notified at	by Fu	1 Never Married 2001 Narried 3 Widowed 4 Divorced	Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:			eciry Cuba 2⊠ No	Specity:	Риепо Кіс	an, etc.)	Specify: W	Vhite, etc. hite	
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and	ntal H od otl	Be	17. Father's Name (First, Middle, Last) Lawrence A. Bowe					18. Mother		irst, Middle, Mi la Beicl	aiden Sumame)		
Ž	2 should be and Mental is marked of raumatic ev	ို	19a. Informant's Name/Relationship (T)		10h	Mailing Addre	s (Street s	and Number			City or Town, Stai	to Zin Codel	
Maryland	th an traul							_			D 20853	16, ZIP C006)	
ē,	Hear Hear		Marguerite Bowe/ 20a. Method of Disposition		20b. Place of	Disposition (N y, crematory or	ame of	-	Date	2	0c. Location - City	or Town, State)
E O	Page:		1 ☐ Burial 2 ☐ Cremation 3 ☐ F • 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		f Heaven		1 1	ebrua 2005	ry 10	ilver Spri	nor Marsyl	and
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta important; if Item 27 is marked eny injury or other traumatic events.		21. Signature Funeral Service Licens Tuckey of L	9e	ii Ç	Franc	niver	s of Facility	ins E	uneral	Home In	С	
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rd	w require been sig should t		Atrial Fibrillat	ion, Con	gestive .	Heart F	allur	·e	_	1 🗋 Yes	2 □ No 3 □	Probably 4	MUnknown .
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<u> </u>	Th ate pag	Соп								performe	ed? death	n? Yes 2□ No	
/ita	iclan: T certificat ector, pa	Be	25. Was case referred to medical examiner?	le ne itali			0.1		of Death (C	check only one)		
of	Phys this al dir	2	1 ☐ Yes 2X No 27. Manner of Death	lospital: 1 Inpati 28a. Date of Inji				4 (ALIVUE			ce 6 Other (S	Specify)	
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Di	i di di	ert	4 Homicide determined	building, e	tc."(Specify)				- }	City or Town,	State)		
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	To the Hosp within 24 ho To the Func completely f	edical	51.0,	and manner si	tated.				occurred				
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1	140		youne	Au.	vang		a5	6691			Februa	гу 8, 2	UU5
ι	67		30. Name and address of person who co				1		~·-	~		000	
		•	Ghousia Sultana, 31. Date filed (Month, Day, Year)		2107 Her:			ırcle	, Sil	ver Spi	ring, MD	20906	
	Sta Registr		FEB 1 4 200	5 Store	rar's Signature	specie							

			State of Maryland / Dep	partment of Health and Mental F	
			, roi	ertificate of Death	Reg. Ng? 005 06852
	Physici	an	1. Decedent's Name (First, Middle, Last) ESTUR BORTMAN	2. Date of Month	Day Year
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- 8- 05 7.30 A M
	Examir	ier	POTOMAC VALLEY NSG. & WELLNESS CTR.	ROCKVILLE	MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		Birth 9. Birthplace (State or Foreign Country)
	Director		054-10-6959 1□M 2√F 85 Yrs.	NOV 1	0, 1919 POLAND
	ow ow	į	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	a-f eh	ctor	MARYLAND MONTGOMERY GARRET	Г PARK	1 □Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	erai	10704 WEYMOUTH STREET 11. Marital Status 12. Was Decedent Ever in U.S. 13	20896	UNITED STATES
(0	r Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13 Vas Decedent Ever in U.S. 14 Vas Decedent Ever in U.S. 15 Vas Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
21215-0036	s within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f ehow the Medical Examinat must be notified at	۾	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 【 No Specify:	Specify: WHITE
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12	l within iene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	KKEEPER	CONSTRUCTION
	e filec al Hyg otha vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mide	
ylaı	should b nd Mente markad umatic e	To	JACOB PECARSKY	HELEN	WRONBERG
Maryland	S S S S S S S S S S S S S S S S S S S			iling Address (Street and Number or Rural Route Number Or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Route Number or Rural Route Route Route Route Route Route Route Route Route Route Ro	
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Baltimore,	permit. Pages Department of I Important: If Its any injury or o		1 🗆 Buriai 2 Ki Cremation 3 Ki Hemoval from State	ematory or other place) L CREMATORY FEB 11, 200	5 FALLS CHURCH, VIRGINIA
alti	permit. Departm Importa any inju			22. Name and Address of Facility DANZANSKY-GOLDBERG MEMOR	TAI CHAPEIS INC
<u> </u>	90 E # 9		1111	11/U RUCKVILLE PIKE, RUC	KVILLE, MD 20852
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o.	that the de led by the a detached f	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	☐ Other (specify)	
۵.	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	by Pł	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Di	id tobacco use contribute to the cause of death?
ord	w require been sig should b	ted l	Presumo ma, Hyperfe	usion 11	☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Records,	e lawr has be	Completed	Dishelus Mellifus,		itopsy prior to completion of cause of
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Vital	S S	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (Check online and 3 □ DOA Other: 4 A sursing Home 5 □ Re	ly one) esidence 6 □Other (Specify)
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	the Ho in 24 tha Fu ipletel	ledical	(Check only 2 Medicel Exeminer; On the basis of examination and/or one) 2 Medicel Exeminer; On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time	ne, date and place, and due to the cause(s)
	To To t	Σ	29b. Signature and title of certifier	29c. License number D 0 0 6 0 0 3 6	29d. Date signed (Month, Day, Year)
,	30		30. Name and address of person who completed cause of death (item 23a) (Typi		2-0-05
			MAHMOUD DOSKI, M.D., 1299 LAMBERTON		20902
•	Sta		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		
	🗼 🤅 Registi	ar	FEB 1 4 2005 Mague 15. 19		

		-	For Stata Registrar	State of Maryland	Department of H Certificate of L			CUUS	06853
			Hegistrar Decedent's Name (First, Middle, Last)		Ochinoate of E	Jean	Rag. N	lo.	3. Time of Death
	Physicia		CARRIE 7	- BROWN)		FEB &	ay Year	3:50 m
	/Medic Examin		4a. Facility Name (If not institution, give :		4b. City, Town, or	Location of Death		c. County of Death	
			WASHINGTON .	ADVENTIST	TAKO	oma F	ARK I	MONT	GOMERY
	Funeral		5. Social Security Number 6. Sex		birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign
	Director	-	511306234	M 2AF 83	Yrs.		MAR 26	1921	<u> "S.C.</u>
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	-			10d. Inside City Limits
	Mary 1 sho	io.	DC	WIX	+SHINGTO	IAC			1 XYes 2 □ No
	r 28e	rec	10e. Street and Number	107	10f. Zip Code	010	10g. (Citizen of What Cou	intry?
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	ems	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi	spanic Origin? (S)	pecify Yes or No-	14. Race - Amer Black, White	
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21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-1 show the M. circal Examiner must be notified at	q pe	3 Widowed 4 Divorced	Year or Dates:	So Decederal Head Course	Hinn	100	12	LACIS
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/lar	tould be I Mental narked c	To E	JOHN SIN	NS		CATH	ERINE	MOR	MAN
Maryland	2 sho and I Is me		19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street a	and Number or Ru			
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	- 22		23a. Part1. Enter the disease, or compl	ications that caused the death. [JASK DO	Approximate
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Box (death certific e attending p od for use as	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of deliv	rery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal de 4 Pregnant at time of death				Month	Day Year
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Division	Attendi er death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home	a, farm, street, factory, office		28f. Location (Street		al Route Number,
Ö	s afte	Certification:	4 Florificide	building, etc. (Specify)			City or Town, Sta	119)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Cartifying Phy (Check only 2 Madical Exami	sician: To the best of my knowle inar: On the basis of examination	edge, death occurred at the time	ne, date and place	, and due to the cause	(s) and manner as	stated.
	the hin 2, the mplet	Med	one)	and manner stated.	29c. License			Date signed (Month)	
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0	,		30. Name and address of person who co			JX (J) 2	d d	-10-0	x UUU
1			CHANDRA KO			HANO	JER PKW	14 CORFI	PUBELT M
	Sta	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signature	8	, , , , , , , , , , , , , , , , , , , ,	250 - 1500	2	DUBELT M
	Regist	rar	FEB 1 6 2005	Maria.	Brooks)				•

State of Maryland / Department of Health and Mental Hygien 06854 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 11, Lorraine Y. Benson-Henson 2005 3:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Cheverly County Hospital Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2600F Director 578-54-8417 68 1936 Washington DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ir then "naturel", or items 23e or 28e-f show the Medical Examinar must be notified at Director 1 Yes 2 No MD Prince George's Adelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 1801 Metzerott Rd United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Dep intent of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Item any njury or other traumetic event, the Medical Examinat Once. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☒ No þ 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Starkey Dorothy Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aprelle Henson / Granddaughter 4545 Wheeler Rd #301 Oxon Hill Md 20745 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State XI Surial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 2/17/2005 * 4 ☐Donation 5 ☐ Other (Specify) Landover Md Park Cemeter Address of Facility S. Pope Funeral Home Alexander S. Pope Funeral Home 21 Signature of Funeral Service Licensee Penn Ave SE Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of). Examiner DIRA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 UMONIA Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2700
9 Unknown 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Nonknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XX 1 Phopatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Accident 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Hospitel retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Types Print) 16. J. RAO, MD - 4800 - MT CHELL WHE Bowie. Road, # 220; 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 1 6 2005 Registrar

			for State Registrar	State of Ma	•	•	ent of H			-	giene Reg. No.	200	5	06855
ı	Physicia	an	Decedent's Name (First, Middle, Last	,						2. Date of De Month	Day	Yea	ır	. Time of Death
	/Medic Examin	al	VIRGINIA THERESA 4a. Fecility Name (If not institution, give			4b. C	ity, Town, o	r Location of		Februar	_	2005 County of De		9:00 a [™]
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Maryland 21215-0036	72 hou natura lical E		15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's L	Jsual Occup	ation	t of worki	na	16b. Kir	nd of Busines	ss/Industr	ry
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Fune Direc vt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.
Transit If them 27 is marked other than "natural", or items 23a or 28a-f show draw or other treatments. Baltimore, Maryland 21215-0036

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Physici /Medic Examir

To the Hospitel or Attanding Physician: The taw requires that the death certificate be executed within 24 hours after death.

To the Funarai Director: After this certificate has been signed by the attending physician and completely filled in by the tuneard director page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Salisbury Reab/Nursing Center 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex Yes 95 10. City Town or Location Maryland Wicomico Salisbury 10. City Town or Location Salisbury 10. Sipcode 10. Sipcode Interest of Description 10. Sipcode Interest or U.S. Amed Forces? 11. Marial Sitatus 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Crigin? (Specity Vas or No-Invest Marial Sitatus 14. Real Forces? 15. Specify Cuban Medican, Peerlo Rican, etc.) 16. Since Interest Marial Sitatus 17. Seal Security (0-12) 18. Decedent's Execution (Give Price And Compileted) 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Date (0 or as a consequence of): 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Mailing Address (Street and Number or Rural Route Number, City or Town 19. Date (0 or as a consequence of): 20. Date (0 or as a consequence of): 21. Use of the Street of the Rural Rural Rural Rural Rural Rural Rural Rural Rural Rural Rural Rural Rur	105 0606	
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Samuel S	10d. Inside City Limit	
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19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Alicia A. Bomhardt/granddaughter 143 Creekside Dr., Darjsboro, DE 20a. Method of Disposition 20 Burual 2 © cremation 3 Removal from State 14 Donation 5 © Other (Specify) 25 Siloam 27 Name and Address of Facility 27 Name and Address of Facility 27 Name and Address of Facility 28 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 28 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 29 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 29 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 29 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 20 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 20 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 21 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 22 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 22 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23 Part III Route the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23 Part I Part	Of Maryland	
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25. Was case referred to medical examiner? 1	Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	
3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide) 28f. Location (Street and Numicide)		
29a. Certifier 12 29a. Certifier 14 Check only 26 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my opinion, death occurred at the time, date and place.		
one) and manner stated. 29b. Signature and title of certifier 29d. Date signed	anner as stated. and due to the cause(s) and (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	205	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Yee Mattie Adelia Beasley Feb. 2005 2:45p /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner So. Maryland Hospital Clinton Prince George If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 96 yrs. Birthplece (State or Foreign Country) **Funeral** 1 □ M 200 F **Director** 246-54-7419 2/17/1908 N.C. Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County ?7 ie marked other then "natural", or iteme 23e or 28e-f ehow traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Charles MD Director LaPlata 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8750 Dream Crt. 20646 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ White 3 ∑Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service 12 Postmaster 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles M. Cayton, Sr. Martha Morrisette Cayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le eny injury or other trau 8750 Dream Crt. LaPlata, MD 20646 Carolyn Meiggs/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Charlotte Hall * 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Crem. 2/13/05 21. Signature of Funeral Service Licensee Card 22. Name and Address of Facility LBPYa567MD 20646 MO0945 23a. Pert1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hyponatromia
Du to (or as a consequence of): attending physicien and Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19518 DR. Rozanio -30. Name and address of person who completed cause of death Atem 23a) (Type, Print) Kosario FERNANDEZ 7700 OLD BRANCH AVE. CLO2 CLINTON, MD. 2073) 31. Date filed (Month, Day, Year) FEB 1 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 12 2005 7:33 A M ROBERT DANIEL BUCKLER, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) SEP. 5, 1950 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** 153M 2□ F MARYLAND Director 54 214-58-1112 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28e-f show other treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 XNo Director ST. MARY'S MECHANICSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 U. S. A. 29754 ALLEN ROAD Funerai permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural" one any injury or other treumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4∑Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE APARTMENT COMPLEX 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES GEORGE BUCKLER MARGARET ELIZABETH WOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29754 ALLEN ROAD MECHANICSVILLE, MARYLAND 20659 MARGARET E. BUCKLER/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY FEB. 17, 2005 SUITLAND, MARYLAND * 4 ☐Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL. HME., P.A. MO0641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cardiac any **Physician** 17 Krown resulting in death) /Medical Due to (or as a consequence of): **Examiner** Congestini Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 2 10 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ot for MID Type. Print)
9201 Georgis Are Swit 3-415: Unispring 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 ROINTAN FARAHIFAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 5 2005 Registrar

			1- State of Ma	ryland / Depar <i>Cert</i>	rtment of He			ene . No. 200	15 NERSO
	Physici	20	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Y	3. Time of Death
	/Media	cal	Lillie Pearl Banks		# 00 T		February		
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County of	
	Funeral			(In yrs. last birthday)	If Under 1 Year	Clinton If Under 24 Hrs.	8. Date of Birth		ce George's Birthplace (State or Foreign Country)
	Director		578-54-4609 1□M 2ĂF	83 Yrs.	Months Days	Hours Min.	(Month, Day,) Mar. 21,	1921	Virginia
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limits
	Maryl -f sho	ţō	DC	,		II a a la d'an a de			1 XYes 2 No
	n tha	Director	10e. Street and Number		10f. Zip Code	Washingt		. Citizen of Wha	at Country?
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	tems	by Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. W	as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, WA도면요n
36	rs afte	oy F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XVI If Yes, Give Year or Dates:	1[☐ Yes 2☐XNo	Specify:		Specify:	American
21215-0036	72 hours after death with tha Maryland 'naturel', or items 23s or 28s-1 show disal Evantiner must be notified at	ted t	15. Decedent's Education	16a. Decede	ent's Usual Occupation	on	16	b. Kind of Busin	ness/Industry
215	thin 7. B. an "n Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-4)	life, Do	ind of work done dur O NOT use retired)	ring most of workir	ng		
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and	ntal H ad oti	Be	17. Father's Name (First, Middle, Last)		18	8. Mother's Name	(First, Middle, Ma		
Maryland	should ad Me mark matic	우	John Webster 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and	d Number or Rura		Burgess	ate Zin Code)
	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at ance.		Rose M. Butler - Daughter		09 Ridgec				20746
Baltimore,	ss 1 and 2. of Health ar item 27 is		20a. Mathod of Disposition	20b. Place of Disposi	ition (Name of atory or other place)	D	ate 20	c. Location - Cit	y or Town, State
Ĕ	Page ment ant: If ury o	١.,	1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Lincoln M		em. 2/10	/2005	Suit1	and, MD
3alt	Departi Departi Import any Inj once.		21. Signature of Flur eral Service Licentus	171	Name and Address		tewart F		
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	w requiras that been signed b should be deta	by	Part II. Other significant conditions contributing to death but Diabetes Mellitus, Hyp	-	, ,				ite to the cause of death?
División of Vital Records,	The law rete has be page 2 sh	Completed	failure on dialysis, I Arrythmia of the Heart	_	Vascular	Disease,	24a. Was an autopsy performe	d? prio	re autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
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	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 7 2005	r's Signature	W				

			For State	State of M	aryland / D	epartme Certifica			d Mental Hy	giene Reg. No. 20	NE	00000
			Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of D	eath	UU	3. Time of Death
	Physici		Mary E. Bailey						Feb	Day 06 20	Year O.5	11:28 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City	, Town, or	Location of De		4c. County		
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28	Funeral		Social Security Number 6. Sex	7. Ag	ge (In yrs. last birth	Months	Pr 1 Year Days	If Under 24 H		irth		lece (State or Foreign
	Director		215-36-0307	IM ZCZ	67 Y	rs.			June 1		MD)
3=	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
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3 3	the Maryla 28s-f ahor	rec	10e. Street and Number				ip Code			10g. Citizen of	What Cour	ntry?
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-	items 2	by Funeral Director		12. Was Decedent Armed Forces?		13. Was Dec	edent of Hi	spanic Origin?	(Specify Yes or N erto Rican, etc.)	o- 14. Rad		can Indian,
္သုတ္ခ်	after or ite	F	1 ☐ Never Married 2 ☑ Married	1 Yes 2		1 🗆 Yes		Specify:	eno rican, etc.)			
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305	should and Men to marke	-	19a. Informant's Name/Relationship (Ty		19b.	Mailing Addres	s (Street a	_	Rural Route Numi		State, Zip	Code)
アる	nd 2 alth a 27 ls		Robert Lee Bailey	/husband	11	11 Gunh	v St	Snow	Hill, M	21863		
13. C.	es 1 and 2 should be filed of Health and Menlal Hygic fitem 27 Is marked other r other traumatic event, II		20a. Method of Disposition		20b. Place of	Disposition (Na , crematory or	me of		Date	20c. Location	City or To	own, State
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4		Ď.	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each li	d the death. Do no							Approximate Interval Between
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125	Physician: The la r this certificate has ral director, page 2	To B	examiner?	lospital: 1 Inpati	ent 2 ER/Out	patient 3 C	OA Othe	er: 4 🗌 Nursin	g Home 5 Res	sidence 6 Oth	er (Specif	y)
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Division	Attendir death. ctor: Af y the fu	ertification;	2 Accident investigation			М		Yes 2□No				
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	Hospital or Attending Physicien: 4 hours after death. Funeral Director: After this certificiely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemi	ner: On the basis of	of examination and							
	To the Hospital c within 44 hours af To the Funeral D completely filled in	Med	one) 29b. Signature and title of certifier	and manner st	tated.	2	c. License	number		29d. Date signe	d (Month	Dav. Year)
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	St.	ate	31. Date filed (Month, Day, Year)	32. R	rar's Signature		~ //!	50,	10 700	ARCH L	W 38	1011
	Regist		FEB 112	005	ever H	board						

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death

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2	Physici	an	Decedent's Name (First, Middle, La					2. Date of De Month		Year	3. Time of Death
	/Medio	al		Jane BRADY				Februa			10:25 A M
	Examir	er	4a. Facility Name (If not institution, give		6	4b. City, Town, or L Bethes		1		ty of Death	
-			9707 Old Georgeto 5. Social Security Number 6.3		rs. last birthday)		ua. If Under 24 Hrs.	8. Date of Bir		ntgom	
	Funeral Director			I N ADE	91 Yrs.	Months Days	Hours Min.	May 17	, 1913	Ohi	place (State or Foreign intry) O
	land w		10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	e Mary	ctor	Maryland Montgo	mery	Bethe	sda					1 □ Yes 2 No
	ith th	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	intry?
	23a	rai	9707 Old Georget	own Road #230	6	208	14		United	Stat	es
920	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show shoel Exemited of	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 梵Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🗓 No		pecify Yes or No o Rican, etc.)	Spec	ack, White	ican Indian, , etc. .ite
9	72 ho	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupati	on	1.1.	16b. Kind of I	Business/Ir	ndustry
21215-0036	within ene. then "	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done dur DO NOT use retired) memaker	ring most of wor	King	Own :	Home	
þ	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)		1	8. Mother's Nam	ne (First, Middle	, Maiden Suma	ıme)	
ılar	should be fand Mental He marked of umatic eve	To B	Paul Brady				Tessi	e Schre	iber		
Maryland	nd 2 shoulth and N		19a. Informant's Name/Relationship Richard Brady, So			ng Address <i>(Street and</i> Boyd Avenu				n, State, Zij 0912	p Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Speci	XRemoval from State	cemetery, crea	osition (Name of matory or other place) Peace Ceme	tery 02	Date / 22 / 05	20c. Location	a, CA	
Baltir	ermit. P Separtme mportan iny injur		21. Signature of Funaral Service Lice			2. Name and Address orchinsky				a, on	
	Physician /Medical Examiner		23a. Part1. Emil The disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Cardiac Ar	rythmia						Interval Between Onset and Death
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease or know)	b. Due to (or as a cons	equence of):						
3760,	eath certificate be executed attending physicien and for use as the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):						
.O. Box 68760,	o o o	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preduced the second of the second	etal death 3	Ectopic pregnancy Other (specify)				ate of delivionth	ery Day Year
s, P	as the	by	Part II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying cause given	in Part I.				the cause of death?
I Record	The ate his page	Completed						24a. Was auto perfo 1 \(\text{Yes}	osy ormed?		opsy findings available impletion of cause of 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	H			6. Place of Dea	th (Check only o	one)		
of	Physic this c	2	1 ☐ Yes 2 ▼No		ER/Outpatier			ome 5 🔀 Resi			fy)
	ding h. After fune	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	t s 2 □ No	28d. Describe	how injury occu	rred	
Division	or life	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe		reet, factory, office		28f. Location (. City or To		ber or Rura	al Roule Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Certifier 1 X Certifying Pl (Check only one) 2 Medicel Exer	hysicien: To the best of my k miner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	h occurred at the time, vestigation, in my opin	date and place, ion, death occur	, and due to the rred at the time,	cause(s) and m date and place	nanner as s	stated. o the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. License n			29d. Date sign		Day, Year)
			and the second second			D 262	50		02/1/	4/05	

State Registrar Ava A. Kaufman, M.D.,

1 - For State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 5 2005

30. Name and address of person who completed of death (Item 23a) (Type, Print)

8218 Wisconsin Ave., Suite 103, Bethesda, MD

D 26259

29d. Date signed (Month, Day, Year) 02/14/05

		1	State of Maryland / Department of Heal		giene 2005	06862
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physicia		ROBERT EARL BUTTS JR	FEBRU	ARY 3, 2005	1415 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local		4c. County of Deat	
П			JJ EV WESTERNOOT SEEDING	ERSTOWN		SHINGTON
	Funeral		Months Days Ho	Under 24 Hrs. 8. Date of Bil ours Min. (Month, Da	ay, Year) Co	nplace (State or Foreign untry)
	Director		213-42-3300 60	MAY 6,	1944 WES	T_VIRGINIA_
	and *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	daryll f sho	5	MARYLAND WASHINGTON HAGE	ERSTOWN		1√2 Yes 2 □ No
	the A	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	3a or		55 E. WASHINGTON STREET, #1011 21	L740	U.S	.A.
	ours after death with the Marylan rat', or tems 23a or 28a-f show Examiner must be mutified at	Funeral Director		nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	14. Race - Ame Black, White	
9	or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No 1 ☐ Yes 2 💆 No So	pecify:	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show the Medical Examirer must be notified at	d by	3 X Widowed 4 □ Divorced Year or Dates:		16b. Kind of Business/	HITE
7	"natu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	Tob. Kind of Business	muusiiy
12	withir ane. than	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+) FARMER	?	DAIR	Y FARM
	filed withi Hygiene. other thar ent, the N			Mother's Name (First, Middle		
Maryland	ld be lental ked c	To Be	ROBERT EARL BUTTS, SR.	EDNA ANNA FRYE		
ary	shou and M s mer umat		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and I</i>			
177	permit. Pages 1 and 2 should be tiled within 72 hours after dea Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examire one.		DEANNA K. NEAL, DAUGHTER P.O. Box 62, MA	444		767
altimore	of He of He fiten		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
Ĕ	Pag ment ant: t		*4 □Denation 5 □Other (Specify) BOOINSBORO CEMETERY	Feb. 8, 05	BOONSBORO,	
Balt	epart epart nport ny inj		21. Signiture of Puneral Service Libensee 22. Name and Address of		OLD NATIONA	
_	Q □ ≥ 6 0		Paul M. Dean BAST FUNERA	AL HOME BOONS	BORO, MARYL	Approximate
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	The Early	0 -	Interval Between Onset and Death
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	y Faith	~	
н	Examiner		Due to (or as a consequence of): If the stems i on			Years
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2 .	2	16.
	be executed sician and burial-transit	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events c. Chronic Obstruc;	tive Pulon	onary Disa	esc Yeary
ó	an ar an ar irial-tu		resulting in death) Last Due to (or as a consequence of):			
3760	w = w	ical	d			
k 68	certificat nding phy use as th	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d Data of del	iven
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		23d. Date of del Month	Day Year
	the a	Physiclan/M	1 Yes 2 No 9 Unknown			
P.0	The law requires that the death tte has been signed by the atter page 2 should be detached for t		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in	n Part I. 23e. Did	tobacco use contribute to	the cause of death?
Vital Records,	uires signe Id be	d by		1/28	Yes 2□No 3□Pr	obably 4 DUnknown
ò	w requir been si should	Completed		24a. Wa	s an 24b. Were au	itopsy findings available
Re	The law ate has page 2	E		auto per 1 □ Yes	formed? death?	completion of cause of
ta		O		3. Place of Death (Check only	-7-	
<u>></u>	Physician: r this certific ral director,	To B	examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other.	4 ☐ Nursing Home 5 🔀 es	sidence 6 Other (Spe	cify)
J Of	ting Ph I. After th funeral		27. Manner of Death 1 ✓ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		how injury occurred	
<u> </u>	att :: e	atle	2 Accident investigation	2 No	(Chant and blumbanas P.	um I Doute Mumber
Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	(Street and Number or Ri own, State)	arai noute ivumber,
۵	urs at	S	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, of	date and place, and due to th	e cause(s) and manner as	s stated.
	To the Hospital or Atterwithin 24 hours after de To the Funeral Director completely filled in by the	Medical	29a. Certifier (Check only one) 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, (Check only one) 2□ Medicel Exeminer: On the basis of examination and/or investigation, in my opinic and manner stated.	on, death occurred at the time	, date and place, and due	to the cause(s)
	To the within 2 To the comple	₩ W	29b. Signature and title of pertifier 29c. License nu	umber	29d. Date signed (Mont	h, Day, Year)
	->-0		VA Cashe MD D3	> 497	2-7	- 05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5497 DPAL CT. 1	HACERS TOP	21.191)
					111000 100	
1	N-2		TANUER A. PASHA MD 11LL C	11/2 -1.		2/74
1		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11)2 -1. (2/74

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Virginia Beatrice Bean 08:20 M ebruar 21 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept 19 Birthplace (State or Foreign Country) **Funeral** 1□M 2X F 90 Director Maryland 214-14-6222 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 XYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 422 Mitchell Avenue 21740 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after di il Hygiene. other than *natural', or Item 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □ Yes X No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumarts. Manager Retail Clothing Store 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Evans Eva Lena Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Lee Shirk (Daughter) 12533 Ashton Rd. Clear Spring Maryland 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Memor. Pk Feb 24 05 1 ABurial 2 Cremation 3 Removal from State Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home unda 1331 Eastern Blvd N Hagerstown Maryland 21742 My 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Inall **Physician** disease or condition resulting in death) 24 hans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? 1 Yes 2 🖫 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Many er of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 V Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and maintenance and place, and due to the cause(s) and place and place, and due to the cause (s) and place (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name d cause of death (Item 23a) (Type, Print) Campus Kd WH-L 31. Date filed (Month. Year) 32. Registrar's Signature State Registrar

			1- State of Maryland / Dep	artment of Health and N ertificate of Death	nental Hygie Reg	
1	Physici /Medic		Decedent's Name (First, Middle, Last) Tony Christopher BLICKENSTAFF		2. Date of Death Month February	Day Year 7 17, 2005 / O S AM
	Examir		4a. Facility Name (If not institution, give street and number) 201 East Chestnut Street	4b. City, Town, or Location of Death Funkstown		4c. County of Death Washington
	Funeral Director		5. Social Security Number 6. Sex $1120 \text{M} 2 \text{F}$ 7. Age (In yrs. last birthday Yrs. 33 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Youly 9,	9. Birthplace (State or Foreign Country) 1971 Maryland
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or t Maryland Washington Funks			10d. Inside City Limits 12☐ Yes 2☐ No
	h with the P 3a or 28a-	ai Director	10e. Street and Number 201 E. Chestnut Street	101. Zip Code 21734		Citizen of What Country?
30	hours after death with the Maryland tural', or Items 23a or 28a-f show at Executarized by rediffed at	by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ Mo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
215-0036	be filed within 72 hours after death with the Marylar Ital Hygliene. Id other than "natural, or items 23s or 28s-1 show ovent. Its Madical Exactivat India by retilitied at	Completed b	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16t	b. Kind of Business/Industry
7	should be filed with Mental Hygiene marked other that matic event, it e	Be			e (First, Middle, Mai	acing stables den Sumame) e Olinger
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evens.	To	19a. Informant's Name/Relationship (Type, Print) 19b. Maii	ing Address (Street and Number or Run 8 Albert Ave., Gre	al Route Number, C	ity or Town, State, Zip Code)
saitimore,	Pages 1 ar nent of Hea int: If Item 3 iry or other		1 23 Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place) M. Cemetery 2/22	5	c. Location · City or Town, State
Balti	permit. Departminents Imports eny inju		1. Soft Munne	415 E.Wilson Blvd.	, Hagerst	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or is a consequence of):	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
8/00,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Chaese of ir july that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
.O. BOX 68/	death certifi e attending id for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ecords, P	w requires that the s been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Monknown
r	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed 1 Yes 2	
DIVISION OF VITAL	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funatal Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical example? 1	ont 3 DOA Other: 4 Nursing Hold Nork? 28c. Injury at Work? AM 1 Yes 2 DAG reet, factory, office	28d. Describe how in Angle 28f. Location Street City or Town, St	t Ad Number or Rural Route Number.
	To the Hospital or Attenwithin 24 hours after deatl To the Funaral Director:	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place,	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier Deput Medical Exc	29c. License number	29d.	Date signed (Month, Day, Year)
4	/-7 Sta Registr		30. Name and address of person who completed cause of death (Item 23a), (Type, 251 5. Addied St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 2 2005		21742	

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artmen rtificat					ene20	105	06865
	Dhysisis		1. Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Robert Holland Bla			45 075	T	Landin		Feb.		2005 y of Death	8:20 P M
	Examin	er	4a. Facility Name (If not institution, give states 18918 Rolling Road				ersto	Location (of Death			ingto	n
	F		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birthday	If Under	1 Year	If Under		8. Date of Birth			lace (State or Foreign
	Funeral Director		216-20-9395 1X	M 2□F	77 Yrs.	Months	Days	Hours	Min.	Dec. 23,	1927	Cour	MD
	2		Usual Residence of Decedent 10a. State 10b. County		10c. City. Town or L	ocation		_				1	Od. Inside City Limits
	shoy	5		ton	Hagerstov								1 ☐ Yes 2 🔯 No
	28a-f	rect	MD Washingt	LOII	nagersto	10f. Zip	Code			10	g. Citizen of	What Cour	ntry?
3	hours after death with the maryland tural', or Items 23a or 28a-f show al Exentrer must be notified al	Funeral Director	18918 Rolling Road	1		21	742				US		
	death	nera	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Dece If Yes, spe	dent of His	spanic Or n, Mexical	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
g .	or Ite	by Fu	1 Never Married 2 Married	1 X Yes 2 ☐ ! If Yes, Give		1 🗆 Yes					Speci	y: Wh	nite
9500-G1717	tural',		3 X Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a, Dece	edent's Usu	al Occupa	ition		1	6b. Kind of E	Business/In	dustry
<u>က်</u> ်	within 72 ene. then."na fre Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(Giv	e kind of wo DO NOT u	rk done d	luring mos	t of work	ing			
717	d with giene er the	E O	12	4	· · ·	Stock	Bro					nanci	al
	be filed within 72 hours after death with the Marylar tal Hygiene. Ital Hygiene. Id other then: "natural; or Items 23a or 28a-f show event. Ite Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	1 - 4 - 1, 1						e (First, Middle, M			
<u> X</u>	should be filed within and Mental Hygiene. s marked other then." umetic evant, Ite Ma.	은	William Carroll B		10h Mai	ling Addros	/Stroot a			e (unk)] al Route Number,			Code)
Š	es 1 and 2 should b of Health and Ment f item 27 Is marked r other traumetic e		19a. Informant's Name/Relationship (Typ. Robert B. Blatchle		102	Live (Dak D	r.,	Wrig	htsville	Beach	NC 2	8480
Baltimore,	permit. Pages 1 a Department of Hex Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Disp cemetery, cre	ematory or	other place				00c. Location		
	iit. Pa artmer ortant injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Linear 	1						/2005 Si rald N. I			eral Home
Ba	Deparament of the parament of		1 min Total	Jano						eet, Hage			
			23a. Part1. Enter the disease, of compli- shock, or heart failure. List only on	cations that cause	the death. Do not en	nter the mo	de of dying	g, such as	cardiac	or respiratory arre	st,		Approximate Interval Between
	nysician	à Ti	Immediate Cause (Final disease or condition		FENAL	FAT	LUFE						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	MEW	NA.						
		ner	Sequentially list conditions, any, leading to infine diale cause. Enter Underlying	Due to (or as	a consequence of:	HU.	171 -						
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	_							
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89	leath certifical attending phy i for use as th	Medi	IF FEMALE:					T.					
.O. Box	death certifica e attending ph ed for use as ti	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	□Ectopic p					9	ate of delivi Ionth	ery Day Year
0	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time of death 5		poc.iy)						
_	es De	by	Part II. Other significant conditions cor	ntributing to death b	out not resulting in the	underlying	cause give	en in Part	l.		acco use con	ntribute to t 3 🔲 Prot	he cause of death? pably 4 (Tunknown
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Re	The lav ate has page 2	omp								autops perform	ned?	death?	
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						e of Dea	th (Check only on	9)		inieriu V
<u>></u>	Physicien: this certific al director.	은	1 Yes 2 No	lospital: 1 ☐ Inpati				4014	ursing H	ome 5 Reside	-		(y)
uc	ding P	tlon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury		28c. Injun Worl	γαι ∢? Yes 2.[No	28d. Describe ho	w injury occi	31160	
Division of Vital Records,	il or Attending after death. Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, s c. (Specify)	street, facto	ry, office			28f. Location (Sti City or Town	reet and Nun , State)	nber or Run	al Route Number,
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medicel Exemi	ner: On the basis of	of my knowledge, dea	ath occurred	d at the tim	ne, date a pinion, de	nd place, ath occur	and due to the ca rred at the time, da	use(s) and nate and place	nanner as s o, and due t	stated. o the cause(s)
	o the lithin 2 of the lomplet	Medical	29b. Signature and title of certifier	and manner st	atou.	29	c. License	e number		25	9d. Date sign	ed (Month,	Day, Year)
	T will		I /h m	P			D	005	905	15.	Feb	17,	2005
4	9,1		30. Name and address of person who co	ompleted cause of									
	9+1 St	ate	Dr. Ciaran Browne	20 24:	931 Oak Hi rar's Signature			iager	BLOW	11, FID ZI	144		
	Regist		res 1 7 2	UUD Bee	rar's Signature	Joseph	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lois Marie Boyer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12 1 923 6. Sex 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🔀 F Maryland Director 218-18-4606 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hyglene. 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Example triust by netting at 10d. Inside City Limits 1 Yes 2 No Director Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 17960 Garden Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nancy B. Shank marked William Kiefer Loudenslager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) william Edward Boyer (Husband) 17960 Garden Lane Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any Injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State Greenlawn Memor. Pak | Feb 18 2005 | Williamsport Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 1/suc 23a. Part 1. Enter the diserve, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consquence of Examiner The law requires that the death certificate be executed transit Due to (or as a consequence of): attending physician a I for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month 5 Other (specify) the 9 Unknown 9 Unknow ģ been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 K No 3 Probably 4 Unknown RENAL FAILURE Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 1 Yes 1 Yes No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA No Certification: To 28a. D te of Injury (Month, Day Year) 27. Manner of D ath 1 Natural 2 Accident funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature and little of cert 29c. License number 29d. Date signed (Month, Day Year) 30. Name and address of person who completed cause o death (Item 23a) (Type, Print) 3H-10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Goods

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of H tificate of L	ealth and N Death		giene 2 Reg. No.	005	06867
Н			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Atlen	Bell						ary 13		4:08 P M
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location of Death	1	4c. Cou	nty of Death	1
			Ruxton Nurs	ing Cent	er		Denton			Car	roline	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Birth	place (State or Foreign intry)
	Director	-	415-66-0077		84	Yrs.			April	7,1920	Alab	ama
	and and	1	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary f sho	ō	Manyland Can	oline		Dantas						1 ☐ Yes 2 No
	28a	Director	Maryland Car 10e. Street and Number	orine		Denton	10f. Zip Code			10g. Citizen	of What Cou	ıntry?
	3a or		24847 Beachamp	Road			2162	q		TT	SA	
	ms 2	Funerai	11. Marital Status		cedent Ever in U	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Si	pecify Yes or No	- 14. F	Race - Ameri Black, White	
9	after or ite		1 ☐ Never Married 2 ☐ Marr	ied 1 ☐ Yes	2 No		1 Tes, specify Cuba 1 □ Yes 2 12 No	Specify:	o rican, etc.)		oiack, white, ecify:	, etc.
21215-0036	y within 72 hours after death with the Marylan jiens Itan "natural", or items 23e or 28e-f show Ita Modeal Exa ultrer mast be collified at	d by	3 ▼Widowed 4 □ Divorced	Year or			1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Opcony.			В	lack
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N	# # \$ E	e Co	17. Father's Name (First, Middle,	Last)		п	ome Maker	18. Mother's Nan	ne (First, Middle,		wn Hom	<u>ie</u>
au	iould ba filed I Menta! Hyg harked other hatic event,	m						Este1	, ,		,	
Maryland	should ind Men marke umatic	2	Clifton 19a. Informant's Name/Relations	Hill hip (Type, Print)		19b. Mailir	ng Address (Street a		7.7	Unkno		ip Code)
	and 2 : ealth ar n 27 is		Clezel Bell	/ Son		8830	O Harmony	Road D	enton Ma	rvlan	1 21	629
ନ୍	- I = =		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place		Date		on - City or T	12,000.00
Ê	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	-	Cremator		18-2005	Dove	r.Dela	ware
Baltimore,	permit. Pages Department of I important: if its any injury or o		21. Signature of Funeral Service	Licensee			. Name and Addres	s of Facility			Dera	ware
ñ	89 5 8					-	bennie St 426 Dove	mith Fun r Street	eral Hom Laston,	ne Maryla	and 21	601
	DO F		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	t caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rest,	-6:	Approximate Interval Between
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T	/Medical	.	resulting in death)	Due to	o (or as a conse	quence of):						877107.770
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	ad sit	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Dua v	o (or as a sonse	quanea oty:						
	and I-tran	Examin	that initiated events resulting in death) Last	c. Due t	o (or as a conse	auence of):						
8760,	cate be executed physician and the burial-transit											
387	icate phys s the	edicai		d								
×	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Z/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn					23d.	Date of deliv	/ery
Вох	death a atter	Physician/M	in the past 12 months? 1 ☐ Yes 21 ☑ No	4□Pre	birth 2 Teta gnant at time of a		Ectopic pregnancy Other (specify)				Month	Day Year
o.	res that the designed by the a	hys	9 Unknown	9□ Unk	rnown							
Records, P.O.	s that ined t	by P	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?
ğ	w require been sig should b								10	res 2⊠No) 3 ☐ Pro	bably 4 Unknown
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ž		mo;							perfo	rmed? 2 No	death?	2 No
İ	ysician: The law iis certificate has t director, page 2 s	Bec	25. Was case referred to medica examiner?					26. Place of Dea	ith (Check only o	ne)		-
<u></u>	Physic this ce	<u>ا</u>	1 ☐ Yes 2 ☑ No			ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursing H	ome 5 Resid	dence 6 🗆	Other (Speci	ify)
_ _	Attending Physician: or death. ector: After this certifica by the funeral director. I	on:	27. Manner of Death 1 Natural 5 ☐ Pendir	/4.40	e of injury onth, Day Year)	28b. Time o Injury	Worl	k?	28d. Describe I	now injury oc	curred	
<u>s</u>	tendi leath. tor: A the fu	cati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be				Yes 2 □ No	206 Location /	Stroot and No	mbor or Ru	ral Route Number,
Division of Vital	or Attendations after death	Certification:	4 Homicide determ	nined 28e. Pla	ce of Injury - At I Iding, etc. <i>(Spec</i>	nome, tarm, sti ify)	eet, factory, office		City or Tox		mber or Hur	rai Houte Number,
_	pital ours a oeral filled	2	29a. Certifier 1 Certifyin	na Physician: To t	he best of my kn	owledge deat	h occurred at the tim	ne date and place	and due to the	cause(s) and	manner as	stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical one)	Examiner: On the	basis of examin anner stated.	ation and/or in	vestigation, in my of	pinion, death occu	rred at the time,	date and place	e, and due t	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifie	ır .	/		29c. License	e number		29d. Date sig	ned (Month,	, Day, Year)
			1.	t. Droy			Doo	61688		02/15	5/05	
			30. Name and address of person	who completed ca			-		.145 =	. 1 (4 =		
			DR. RUPAL R.	DESAL	Francisco Company		to Decive,	chestre	MD 2	1619	average and the second	and a second
	Sta		31. Date filed (Month, Day, Year,		. Regionar's Sign	nature	1.00					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** 1130 AM 18 2005 Walter Jay Brown tebruary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1⊠M 2□F 71 Yrs. November 30,1933 Montanna Director 517-34-6416 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h Count 10a State other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director WV Morgan Berkelev Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 47 Blueiav Court USA Items 23e Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Vear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry a filed within al Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) Theology Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pagas 1 and 2 should ba file Department of Health and Mantal Hy Important: If Item 27 Is marked oth any jury or other traumatic event pice. Be Beatrice B. Bruce Walter Joseph Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 47 Bluejay Court Berkeley Springs, WV 25411 Jean Brown/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 02/19/05 Smithsbur, MD 21. Signature o Funeral Service Licens re 22. Name and Address of Facility 141 West Main Street A. Hancock, MD 21750-0368 Grove Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANDIAC ISCHEMIA **Physician** /Medical Due to (or as a consequence of) Examiner TRANSPLANT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine usa as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and fittle of certifier 2005 D59055 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ciran Browne, M.D. 12931 Oak Hill Ave.Hagerstown,MD 21740 32. Redistrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

2005

			1 _ State		artment of Health and Martificate of Death	lental Hygie	ene	0000
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	Tillicate of Death	2. Date of Death	C U Const	3. Time of Death
	Physici		Louise Bennett				^{Day} 15, 2005	13:40 p M
	/Medic Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death	1001441)	4c. County of Death	13.40 p
			Chester River Manor Ho	spital	Chestertown		Kent	
	Funeral Director		5. Social Security Number 219-34-3767 Usual Residence of Decedent	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) May 23,	(ear) 9. Birthp Coun 1915 MD	lace (State or Foreign try)
	land w		10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mary Feb	tor	MD Queen Anne's	Centre	eville			1 ☐ Yes 2X No
	th the	Jirec	10e. Street and Number		10f. Zip Code	100	J. Citizen of What Coun	itry?
	ath w	rai	109 Recovery Drive		21617	US	SA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow appring yor other traumatic avant, the Medical Examiner must be mailted at once.	by Funeral Director	Armed 1 □ Never Married 2 □ Married 1 □ Ye If Yes,	s 2 TYNo	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
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121	within	mpi		(1-40r 5+)	DO NOT use retired) maker		Own Ho	
d 2	Hygie Hygie Sther	ပိ	17. Father's Name (First, Middle, Last)	Home	18. Mother's Name	(First, Middle, Ma		ine
an	ld be ental ked o ic ave	To Be	Harry F. Callahan		Margaret			
ary	shou and M a mar umat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Rura			Code) 19073
	and 2 saith a n 27 is er tra		Harriett B. Humpton/da	ughter P.O.	Box 441, 611 N. Ne	ewtown Sq	. Rd, Newto	wn Sq.,PA
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal fro	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or To	wn, State
Ë	Pag tment tant:		* 4 ☐ Donation 5 ☐ Other (Specify)	Chesterf	ield Cemetery Feb.	.19,2005	Centreville	e, MD
Bal	permit Depar impor any in		21. Signature of Funeral Service Licensee	20	Rellows, Helfenber 130 Speer Road, (Home, P.A.
	rnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter unbestyping	to (or as a consequence of):	Failur ulm, fib	Weig	> \	Approximate Interval Between Onsevand Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events c.	o (or as a consequence of):				
P.O. Box (at the death certific by the attending p tached for use as	Physician/Med	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
Records, F	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
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Vital	yalcla is certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	npatient 2 ☐ ER/Outpatier	26. Place of Death	,,	e 6 □Other (Specify	A
ion of	ding After funer		27. Manner of Teath 28a. a	te of Injury 28b. Time o Injury		28d. Describe how		/
Division	tal or Atters after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla bu	ce of Injury - At home, farm, str Iding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Madical Examiner: On the one)	he best of my knowledge, deat basis of examination and/or in anner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
ı	To Con	2	29b. Signature and title of certifier	7	DI648	8 29d	Date signed (Month, D	Day (Year)
			30. Name and address of person who completed or	√ - 1 M	Print) Chest	erbon	1 Mo	l .
	Sta Registra		31. Date file (Month, Day, Year) 1 6 2005	Registar's Signature	Solo		7	

				Please	Type or Pri					•		•	
			For State		State of M	arylan		artment of I <i>rtificate of</i>		d Mental Hy	200	After the contra	,100k
			Registrar	e (First, Middle, Las	<u>.</u>		Cei	Tuncate of	Dealli	2. Date of D	Reg. No	UUD	- 13 firmer of the arth
	Physici				y Bracke	an				Month	10, Day	2005	9:19 a M
	/Medio Examin				street and number			4b. City, Town, o	or Location of D			County of De	
1	_xaiiii		3908 1	8th Stre	eet			Chesa	peake	Beach	each Calvert		
	Funeral		5. Social Security N	lumber 6. S	ex 7. Ag		last birthday)	If Under 1 Year Months Days		lin. (Month, E	8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)		
	Director		578-20	- 7825	□м 2⁄ДГ	84	Yrs.			8/16,	/192	0	DC
	fand wo		Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
	Mary I sh	to	MD	Ca1	vert			Chesar	eake 1	Beach			1 X Yes 2 □ No
	th the	lrec	10e. Street and Nu					10f. Zip Code			10g. Cit	izen of What (Country?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show iteal Examinat must be multified at	Funeral Director	3908 1	8th Str	eet				20732		L	USA	
	tams	nue	11. Marital Status		12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Po	(Specify Yes or Nuerto Rican, etc.)	0-	 Race - Ar Black, Wi 	nerican Indian, nite, etc.
36	rs afte	by F	1 ☐ Never Marr 3 ☐ Widowed	ried 2 Married 4 ☑ Divorced	1 ☐ Yes 2]X If Yes, Give Year or Dates:	No		1⊡Yes X XNo	Specify:			Specify: W	Thite
5-0036	2 hou	ted t		15. Decedent's Ed	fucation			dent's Usual Occu			16b. K	ind of Busines	
215	hin 73	ple	(Spec	cify only highest gra andary (0-12)	de completed) College (1-4or	5+)	(Give	kind of work done DO NOT use retire	during most of d)	working			
2121	ad with	Completed			1	,		Secret	1		1		Red Cross
nd	be file tal Hy d oth	Be	17. Father's Name	(First, Middle, Last)						Name (First, Middl	e, Maiden	Sumame)	
yla	nould I Men narke	70	Emory '		Europe (Defeat)		405 44-00	Address (Charles		Binnix	has City	Taura Chata	Tie Codel
Maryland	d 2 st th and 7 Is n traun			ame/Relationship				•		Rural Route Num			
6	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Madical Examinating the rediffied at once.		20a. Method of Dis	Rine/Fri	.ena	20b. P	lace of Dispo	sition (Name of		, Chesa			or Town, State
altimore,	Pages ent of nt: If i		1 ☐ Burial 2	Cremation 3 □ 5 ② Other (Specify)	Removal from State	' _	-	matory`or other pla ake Cre	1	11/2005	Bo 1	+ 0 17 1	1e MD
alti	mit. f partm sortar / injui		1	uneral Service Licen		OII		2. Name and Addre	C 100 -				I., P.A.
Ö	Departing Department of the procession of the pr		I find	Abras	-/. MO.	:871		PO Box	430, D	unkirk,	MD	20754	., F.A.
			23a. Part1. Enter t shock, or hea	the disease, or com	plications that cause one cause on each I	ine.			_		arrest,		Approximate Interval Between
	Pnysician	8 1	Immediate Cause disease or condition	on	. con 6	BTIL	1E	HART	FAIL	· un E			Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	uence of):						
		<u>.</u>	Sequentially list co	onditions,	b. Due to (or as	a consequ	uence of):						1
	uted I Insit	Examiner	Cause (Disease or	erlying r injury									
60,	be executed cian and ourial-transit	Еха	that initiated events resulting in death)		Due to (or as	a consequ	uence of):						
176	eath cerificate be ex attending physician for use as the burial	cal		•	d								
(687	ntifica ing ph a as th	Med	IF FEMALE:										
Вох	death ce	Physician/Medical	23b. Was deceder		23c. If yes, outcome	2 Fetal	Ideath 3 [Ectopic pregnanc	у			23d. Date of d Month	elivery Day Year
-	he de the a	yslc	1 ☐ Yes 2 ₹ 9 ☐ Unknown	☑ No	4∏Pregnant a 9□ Unknown	it time of di	eath 5L	Other (specify) _					
, P.O	res that the de igned by the a be detached f	y Ph	Part II. Other signi	ficent conditions of	ontributing to death	but not resi	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco u	use contribute	to the cause of death?
rds	requires een sign nould be	Completed by	ATRIA	- FIBLI	LLATIN	, A	SVAN	CED STE	DARTHA	LITY 10	Yes 2	ZNo 3□	Probably 4 DUnknown
000	aw s b	plete								24a. Wa	s an	24b. Were	autopsy findings available completion of cause of
R	The ate h	Com								per 1 ☐ Yes	formed?	death'	es 2 No
/ita	ician: Th certificate rector, pag	Be (25. Was case references	rred to medical						Death (Check only	one)		
of \	Physis this c	은	1 Yes 2		Hospital: 1 ☐ Inpati		ER/Outpatier	IL 3L DOA		g Home 5 Pres			ecify)
on C	ding f h. After funer	tlon	27. Manner of Dea 1 ☐ Natural	5 Pending investigation	28a. Date of Inj (Month, Da	ay Year)	injury	Wo	rk?]Yes 2 □ No	28d. Describe	now injui	у оссилеа	
Division of Vital Records,	Attended death	fica	2 Accident 3 Suicide	6 Could not be		jury - At ho	ome, farm, str	reet, factory, office					Rural Route Number,
Ö	al or after	Certification:	4 Homicide	30(0)(1)(1)(0)	building, e	tc. (Specify	r)			City or To	own, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only	1 Certifying Ph	ysicien: To the best niner: On the basis	of my kno	wledge, deat	h occurred at the ti	me, date and pl	ace, and due to the	cause(s)	and manner	as stated.
	tha H hin 24 tha F nplete	Medi	one)		and manner s								
	Twit of	~	29b. Signature and	title of certifier	=1 - 1	- >		29c. Licen				_	nth, Day, Year)
			- A	K IS	3/29	do att	22a) (T		358		145	1000	7001
	ID		30. Name and idd	ress of person who	WETCH		1 23a) (Type,	COF A	2+3+216	ck, Mi	-20	678	
	Sta	ite	31. Date filed (Mor		32. Regist	6/					oc.	10	
L	Regist	ar	FEB	3 1 1 2005	Missia.	St.	Spark						

			1- State of Maryland / Department State of Maryland / Department Certific	ent of Health and M <i>ate of Death</i>	lental Hygie Reg.	4000	06871
	Dhunini		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Rose Virginia Brown		February		5 3:45 PM
	Examin	er		ity, Town, or Location of Death		4c. County of Death Anne Arun	
			ruture care chesapane	rnold nder 1 Year If Under 24 Hrs.			
	Funeral Director		Mont		8. Date of Birth (Month, Day, Ye	9. Birth	
			577-24-0974 87 Trs.		June 13,	1917 Vir	ginia
	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Ma	Director	Maryland Anne Arundel Edgewater				1 ☐ Yes 2 XNo
	or 28	Oire		Zip Code	10g.	Citizen of What Cou	ntry?
	ath w		405 Silver Run Road	21037		nited Stat	es
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Item Erath or Items De notitied at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S.	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Ye Year or Dates:	s 2 ☑ No Specity:		Specify: whit	-0
21215-0036	thou stura		15. Decedent's Education 16a. Decedent's U	Jsual Occupation	16h	. Kind of Business/In	
215	within 72 ene. than "na	Completed	(Specify only highest grade completed) [Ink (Give kind of	work done during most of worki T use retired)	ing		330.1,
212	ad with	mo.	homen	aker		own home	
	be filed tal Hygi d other event, L	Be (17. Father's Name (First, Middle, Last)		(First, Middle, Maid	den Sumame)	
yla	2 should be and Mental Is marked (eumatic ev	2	John T. Lee	Nora Du	val Ellis		
Maryland	2 a 2 9		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Addr	ess (Street and Number or Rura	al Route Number, Cit	ty or Town, State, Zip	Code)
	ealth m 27 her tr			va Rd. Ste. 40			
Baltimore,	Pages 1 nent of H ant; If ite ury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (cemetery, crematory)	or other place)		. Location - City or To	
tim	ortmen ortent; ortent; ortent;		'4 Donation 5 Other (Specify) Hillcrest C		15, 2005		
Bal	permit. Pages 1 a Department of Hes Importent: If item any injury or othe		40 4 10000000	o and Address of Facility Jou Duke of Glouces	_		al Home, Inc MD 21401
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the methods, or heart failure. List only one cause on each line.	node of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ma		•	Opset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	`			4.
1	Cxammer		Sequentially list conditions, b. dupn he	opra		14	mon
	ed sit	Examiner	if any, leading to immediate cause Enter Under, in Cause (Disease or injury	4			140
	ificate be executed g physician and as the burial-transit	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):	479			years.
68760,	be e						•
687	ficate physics the	edical	d				
Box	eath certif attending for use a:	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ory
	The law requires that the death cert tte has been signed by the attendin page 2 should be detached for use a	by Physician/M	in the past 12 months? 1 Yes 20100 4 Pregnant at time of death 5 Other	pregnancy (specify)		Month	Day Year
P.O.	at the by th tache	hys	9 ☐ Unknown		_		
S,	as the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
ord	w requir been si should				1 🗆 Yes	2 No 3 Prob	ably 4 ∐Unknown
Vital Record	law r as be	Completed			24a. Was an autopsy		psy findings available appletion of cause of
<u> </u>	The ate h page	Con			performed	death?	2 No
/ita	cien; ertific actor,	Be	25. Was case referred to medical examiner?	26. Place of Death			
) t	Physic this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3			6 ☐ Other (Specify)
n C	fing P	ion	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
Sic	death.	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined	1 Yes 2 No	28f Location (Street	and Number or Rura	I Route Number
Division of	after Direction by	Certification;	4 Homicide determined building, etc. (Specify)	iory, onice	City or Town, St.	ate)	r Houle Number,
_	Hospital 24 hours a Funerel l		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurr	ed at the time, date and place, a	and due to the cause	(s) and manner as st	ated
	To the Hospital or Attending Physicien; The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only one) Medical Examiner: On the basis of examination and/or investigate and manner stated.	ion, in my opinion, death occurre	ed at the time, date a	and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and Little of continer	29c. License number		Date signed (Month, I	
			0	04195	-5	2-11-	05
			30 Name and address of person the completed cause of death (Item 23a) (Type, Brint)	10 Hr 1#	204	10,000 -	11/e MD
			1. Date filed (Month, Day, Year) 32. Agistrar's Signature	ans1119hu	ray /	wees	MILL (MY)
	Sta Registra		11. Date filed (Month, Day, Year) FEB 14 2005	d ,			
					-		

CHASEDAL. HOLLG. 3-15-1924 Baltimore, Maryland 21215-0036

Ex

Fun

Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or items 23e or 28a-1 show

	For State	State of	of Marylar	-					lental Hy	giene	005	069	372
	Registrar			Ce	rtificat	e of l	Death)		Reg. No.	000	000	J I ha
ian	Decedent's Name (First, Middle SEONG	le, Last)	HONG			CI	ΗA		2. Date of De Month Februar	Day	Year 2005	r	of Death
cal ner	4a. Facility Name (If not institution	n, give street and nu			4b. City.		Location		rebluar		county of De	8:1	5 p
ici	Laurel Regiona				Lau								
	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs.	8. Date of Bir	h		eorges	
	217.04.2042	15☑M 2□F	80	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb. 15	y, Year)	2/1 12	irthplace (State Country)	o o r o o g
	Usual Residence of Decedent								reb. 13	, 1,72	24 1	orea	
	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits
to	Maryland Prince	e Georges	B.	eltsvil	116							1 □ Ye	es 2 🔀 No
Director	10e. Street and Number	0001800		CICOVII	10f. Zip	Code				10g. Citize	n of What C	Country?	
0	4204 Howard Ro	ad			20	0705					rea	ĺ	
Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.			spanic Or	igin? (Spe	ecify Yes or No			nerican Indian,	
긆	1 ☐ Never Married 2 🔀 Mar.	ried Armed Fo			f Yes, spec	ify Cuba	n, Mexica	n, Puèrto	ecify Yes or No Rican, etc.)		Black, Wh		
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	ve		1 ☐ Yes	2 🔼 No	Specify.			S	pecify: ${f A}$	sian	
Completed	15. Deceden	nt's Education est grade completed)		16a. Dece				a a d complet		16b. Kind	d of Busines:	s/Industry	
)dr	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wor DO NOT us	e retired)	N OI WOIKI	ng				
ő	6th			Farme	r					Agri	Lcultu	ral	
Be (17. Father's Name (First, Middle,	Last)					18. Moth	er's Name	(First, Middle,	Maiden S	umame)		
20	Bong Nim Cha						Yang	Sim	Cha				
	19a. Informant's Name/Relations	ihip (Type, Print)		19b. Mailir	ng Address	(Street a			I Route Numbe	r, City or T	Town, State,	Zip Code)	
	Jae Young Cha	/ Son		4204	Howan	d Ro	oad.	Belt	sville,	Mary	land	20705	
	20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of	a)		ate			r Town, State	
	1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S		State	cbeck N			1	2/13	/2005	01nev	. Mar	vland	
	21. Signature of Funeral Service	Licensee		22	. Name an	d Addres	s of Facili	y Hi	nes-Rin	aldi	Funer	al Home	e, Inc
	Nancy A.	. Le cent	Tu.						Ave. S				
	23a. Part1. Enter the disease, or shock, or beart failure. List	complications that c	aused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,	. opii	Approxim	ate
	Immediate Cause (Final	-										Interval Be Onset and	d Death
	disease or condition resulting in death)	a. Pneun	nonla (or as a conseq	uence of):									
					1								
e	Sequentially list conditions, if any, leading to immediate		rovascu		clder	15							
amlner	Cause (Disease or injury	<	,	,									
Exar	that initiated events resulting in death) Last	c. Due to	or as a conseq	uence of):								_	
			,										
g		d											
Me	IF FEMALE:	230 16 1100	come of pregna	anou.									
	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre					230	d. Date of de Month	olivery Day	Year
by Physician/Medical	an the past 12 months:												

Exami To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial tran Division of Vital Records, P.O. Box 68760,

Physic /Medi

> Be Complete Medical Certification; To

Dysphasia 25. Was case referred to medical examiner?

> 27. Manner of Death 1 Natural 2 Accident 3 Suicide

1 ☐ Yes 2 No

4 Homicide

29a. Certifier (Check only one)

1 24 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Hospital:

1 XInpatient

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28b. Time of

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

D-42580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3□ DOA

М

February 9, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed? 2⊠ No

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

5632 Annapolis Road #13, P.S. Aujla, M.D.

31. Date filed (Month, Day, Year)

FEB 1 4 2005

5 Pending

investigation

6 Could not be determined



Bladensburg, Maryalnd 20710

State

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per doc_8846 8-8-05 vt

			1 - State Registrar	State of Mar		artment d ertificate			giene Reg. No.	005	06873
П			1. Decedent's Name (First, Middle, Last,)				2. Date of De	ath Day	Yeer	3. Time of Death
	Physici /Medio		JOSEPH		СОН	EN		FEBRUA		2005	10:45P ^M
	Examir		4a. Facility Name (If not institution, give				n, or Location of De	eath	4c. Co	unty of Death	
			MONTGOMERY GENERAL 5. Social Security Number 6. Se		In yrs. last birthday		OLNEY ear If Under 24 H	Irs. 9 Date of Bir	th		OMERY place (State or Foreign
	Funeral Director				86 Yrs.			lin. 8. Date of Bir (Month, Da AUG 2,	1918	OHIC	ntry)
_			Usual Residence of Decedent					1100 2,			
	show	_	10a. State 10b. County MARYLAND MONT	GOMERY	0c. City, Town or L	ocation LLVER SI	PRING				10d. Inside City Limits Y Yes 2 □ No
	be Mi	Director	10e. Street and Number	GOTTERT		10f. Zip Co			10a Citizan	n of What Cou	
	with I		15107 INTERLACHEN	DRIVE #100	4		5-5634			J.S.A.	nuyr
	death with the Maryland ms 23a or 28a-f show	Funerai		12. Was Decedent Eve		Was Decedent	of Hispanic Origin?	(Specify Yes or No		Race - Ameri	
٥	or ite		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☐ Xio If Yes, Give		1 Yes, specify	Cuban, Mexican, Pu No Specify:	ιθπο Hican, θτς.)		Black, White, ecify: WHI	
-0035	d within 72 hours after death with the Marylan Jane. Ir then "neturel", or items 23a or 28a-1 show Ir a Medical Examinati assi he neilihad at	d by	3 Widowed 4 Divorced	Year or Dates:							
<u>.</u>	n 72 h	ompieted	15. Decedent's Edu (Specify only highest grad	e completed)	(Giv	edent's Usual O e kind of work d DO NOT use n	one durina most of v	working	16b. Kind	of Business/In	dustry
7	l withi	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	PAPER	PRODUC	S DISTRIE	BUTOR		PAPER	
5	othe ent,	Be C	17. Father's Name (First, Middle, Last)		'		18. Mother's N	Name (First, Middle	, Maiden Su	тате)	
yland	2 should be and Mental is marked creumatic ever	Jo E	SAMUEL COHEN				BESS	SIE DYNOF	SKY		
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or pher treumatic evones.		19a. Informant's Name/Relationship (T) ESTHER L. COHEN-WI		F	•	reet and Number or				Code) G,MD20906-
ອ ອ	1 and Health em 27		20a. Method of Disposition		20b. Place of Disc	osition (Name o	of .	Date		ion - City or To	5634
Ď	Se = 30	4	1 StBurial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cri	ematory or other	place)			MARYL	
gairimor	artme ortan Injur	1	*4 □ Donation 5 □ Other (Specify) 21. Signature of Poperal Service Licens				GDNS 2/11 duess of Facility SAGEL FUNI				IAND
ñ	Den Imp	1	Laxun	\supset		EDWARD :	SAGEL FUNI	EKAL DIKE IKE, ROCK	VILLE,	MARYL	AND 20852
	7		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	e death. Do not er	nter the mode of	dying, such as card	diac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		NIC SHOCE	ζ					Onset and Death 6 HOURS
	/Medical Examiner		resulting in death)	Due to (or as a							
	- Administr	<u></u>	Sequentially list conditions,	b. ACUTE MY Due to (or as a c	OCARDIAL	INFARC	CION				12 HOURS
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	333 13 (31 43 4 3							
s s	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a c	consequence of):						
g/60,	ficate be executed physician and s the burial-transit	dicai	(d							
٥	entifica ling pt e as tl	0	IF FEMALE:								
X Q	death certifi e attending id for use as	ician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tin	Fetal death 3	□Ectopic pregr □ Other (specif			23d	 Date of delive Month 	ery Day Year
j	the de	Physic	1	9 Unknown	ile or dealin 3	Other (specif	//				
7	res that the death certificing to the attending to be detached for use as	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying caus	e given in Part I.	23e. Did 1	obacco use	contribute to t	he cause of death?
Records,	w requires that been signed b should be dete		HYPERLIPIDERMIA					1 🗆	Yes 2□N	lo 3□Prob	oably 4X)Unknown
000		ompleted						24a. Was	an 2	4b. Were auto	ppsy findings available impletion of cause of
	The ate his page	Com						perfo 1 ☐ Yes	rmed? 2X No	death? 1 ☐ Yes	
VIIai	ystcien: The taw is certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	Joanital:		37		Death (Check only	one)		
0	this ald	2	12 Yes 2 No 27. Manner of Death	1 Anpatient 28a, Date of Injury	2 ER/Outpatie			g Home 5 Resi			ý)
0	ding Ph h. After th funeral	cation:	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Injury	M	Injury at Work? 1 Yes 2 No				
UNISION	el or Attending F s after death. I Director: After d in by the funera	fica	3 Suicide 6 Could not be	286. Place of Injury	- At home, farm, s	treet, factory, of	fice	28f. Location (Street and N	umber or Rura	al Route Number,
5	pitel or Al ours after o ierel Direc filled in by	Certifi	4 Homicide	building, etc.	эр в спу)			City or To	wn, state)		
	To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	edical ((Check only 2 Medical Exam	sician: To the best of e	kamination and/or i	ith occurred at to nvestigation, in	ne time, date and pla my opinion, death of	ace, and due to the ccurred at the time,	cause(s) and pla	d manner as s	tated. the cause(s)
	To the within 24	Med	one) 29b. Signature and title of certifier	and manner state	d.		cense number			igned (Month,	
	1		b (ild of)	lal.	V ws		29300			ARY 9,	
	C		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type	, Print)					
			DR. ROBERT L. GOLI), 18101 Pr	ince Phi	lip Dri	ve, Olney	, Marylan	d 208	332	
	Sta		31. Date filed (Month, Day, Year) FEB 1 4 2	32. Agistrar	s Signature	barte					
	Regist	100	1 1 1 1 1 1 1 1	UUU I II MELAK	1 10						

			For Stete Registrar		State of Ma	•	epartment of F Certificate of I		d Mental Hy	ygiene Reg. No. 005	06874
	Physici			e (First, Middle, Las		G=114			2. Date of D Month	eath	
	/Medic Examir		4a. Facility Name (xander G. street and number)	COLLINS	4b. City, Town, o	r Location of E		4c. County of Dea	, , , , ,
	Lxaiiii				y Hospital	L	Lanha	am		Prince (George's
	Funeral		5. Social Security I	Number 6. S		e (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24		irth 9. Bir	rthplace (State or Foreign
	Director	Į	242-28-3 Usual Residence of	121	A, iii 201	82 Y	rs.		Nov 1	3, 1922 Nor	th Carolina
	yland yland		10a. State	10b. County		10c. City, Town	or Location			<u></u>	10d. Inside City Limits
	ith the Marylan or 28e-f ehow	हु	Maryland	Prince G	eorge's		Glenn I	Dale			1½∑Yes 2 ☐ No
	ith th	Directo	10e. Street and Nu				10f. Zip Code	760		10g. Citizen of What C	ountry?
	within 72 hours after death with the Maryland ene. than "naturat", or items 23a or 28e-f ehow he Modeal Excriting roust be notified at	ara		artin Ave	nue 12. Was Decedent	Ever in U.C.		769	2 /Cassib. Van a. N	USA	
	fter de	by Funeral	11. Marital Status 1 Never Man	ried 2 Married	Armed Forces?		 Was Decedent of H If Yes, specify Cuba 	in, Mexican, P	uerto Rican, etc.)	0- 14. Race - Am Black, Whi	
5-0036	rat', o	lby	3	4 Divorced	1 Yes 2 □ t If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2X No	Specify:		Specify: W	nite
5-0	"natu	Completed	(Spe	15. Decedent's Ed	lucation de completed)	- (Decedent's Usual Occup Give kind of work done	during most of	working	16b. Kind of Business	/Industry
2121	within ene. than	dmo	Elementary/Sec	ondary (0-12)	College (1-4or 5	5+)	life. DO NOT use retired Upholster	*		Privat	te
9	filed withi Hygiene. othar than	Be Co	17. Father's Name	(First, Middle, Last)				•	Name (First, Middle	e, Maiden Sumame)	
/lan	should be filed within 72 hours after death with a Mental Hygiene. marked other then "natural" or items 23a matic avent, the Medical Examilier, the final case.	To B	Ruben	G. Colli	ns			S	Sadie Woot	ten	
Maryland	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		_	lame/Relationship (1 Gauna (Da						ber, City or Town, State,	Zip Code)
	permit, Pages 1 and 3 Department of Health Important: If Itam 27 any injury or othar tr. 2059.		20a. Method of Dis		ugiicei/		Box 2159,] Disposition (Name of	Leonard	Date Date	20c. Location - City or	Town State
Baltimore,	Pages nent of I nnt: If it: ury or o		1 Surial 2		Removal from State	cemetery	crematory or other place Heaven Cer	.		Silver Spri	
al‡i	permit. Pag Department Important: I any injury o			uneral Service Lacen		Gate O.		ss of Facility	Rendon/Hai	le Funeral H	Home
m	permi Depar Impor any ir		911	hau ,	Poul					am MD 20706	
			shock, or hea	art failure. List only	plications that caused one cause on each li	ne.	t enter the mode of dyin	_			Approximate Interval Between Onset and Death
	Physician /Medical	/	Immediate Cause disease or conditi resulting in death)	00	a. //\	DCAN	DIAC _	INFI	ANCTI	٥N	Cristi and Dealit
	Examiner			- (Due to (or as	a consequence of	DIAC _	7-0	IT MUT	OBTU	
		ner	Sequentially list of it any, leading to it cause. Enter Und Cause (Disease of	onditions, mmediate	b. Due to (or as	a curisequence u	j	,		1	
	ecuted and transi	Examiner	Cause (Disease of that initiated event resulting in death)	S	c		\				
68760,	ificate be executed g physician and as the burial-transit	al E)	rooming in oodin,		Due to (or as	a consequence of).				
687		edical			. d						
Вох	- 0.10		IF FEMALE: 23b. Was deceder		23c. If yes, outcome	of pregnancy 2 Petal death	3 ☐Ectopic pregnancy			23d. Date of de	livery
O. B	O O	sicie	in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	□No	4☐Pregnant at		5 Other (specify)			Month	Day Year
σ.	ac ac	Completed by Physician/M		(100 mag)	ontributing to death b	ut not resulting in	he underlying cause give	en in Part I.	23e. Did	tobacco use contribute to	o the cause of death?
of Vital Records,	uires tha signed I Id be det	d by					, , , ,				robably 4 Únknown
00	law requir as been si 2 should	olete					-		24a. Wa		utopsy findings available
Re	The lav	mo							— auto perf	ormed? death?	completion of cause of
/ita	ysicien: The l is certificate ha director, page	Bec	25. Was case refe examiner?	rred to medical	L				Death (Check only		
of	Physicien: this certific ral director,	10 To	1 ☐ Yes 2 ☐ 27. Manner of Dea		Hospital: 1 ☐ Inpatie		100000000000000000000000000000000000000	4 1401211	7	idence 6 Other (Spe	ocify)
		tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da		ury Worl	Yes 2∐No	Zou. Describe	how injury occurred	
Division	or Attendiater death. Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined			n, street, factory, office			(Street and Number or Ri wn, State)	ural Route Number,
	itel or A irs after ral Dirac led in by				Dandang, de	c. (Opecny)			0.07	, Otato)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)	1 ☑ Certifying Ph 2 ☐ Medical Exan	ysician: To the best niner: On the basis of and manner sta	f examination and	death occurred at the tin or investigation, in my of	ne, date and pi pinion, death o	lace, and due to the occurred at the time	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and	title of certifier	>/		29c. License	e number		29d. Date signed (Mont	h, Day, Year)
)			1				MO 0	5818	2	2-15	-05
(U	(10)		30. Name and add		completed cause of d	eath (Item 23a) (T	ype, Print)	1111/	inem hels	2-15.	770
1	Sta	ate	31. Date filed (Mor		29. Registr	ar's Signature		wy, (N emploce	-,1110 00	, , , ,
	Regist	rar	FF	B 1 6 200		L	And Inc.				

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		ı	For State	State of Ma	aryland		artment of H		nd Mei	-	- 4	005	06875
			Registrar 1. Decedent's Name (First, Middle, Las	:1)		Cei	unicate of	Dealli	2	Date of De	Reg. No.		3. Time of Death
	Physicia	an	Marjory Mur		lark					Month	Day		CHO LO A
	/Medic		4a. Facility Name (If not institution, give	1- 1	TOTI		4b. City, Town, o	r Location of I		ebru		County of Dea	
	Examin	er	0 . 1	, , ,	Co h		Solie	6.01	Bouin		1	Nicom	
	Funeral		5. Social Security Number 6. S		e (In yrs. I	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8.	Date of Birt (Month, Da			thplace (State or Foreign ountry)
	Director		109–14–6874	□M 2 ⊠ F . 8	3	Yrs.	Months Days	Hours	Min. 2	/18/19	у, үе <i>аг)</i> 921		w York
	Du 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation						10d. Inside City Limits
	shor	'n	Maryland Wicom	ui co		Salisb							1X Yes 2 No
	the N	Director	10e. Street and Number	100		Dalisk	10f. Zip Code				10a Citi	zen of What C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examination and injury or other traumatic event, the Madical Examination and once.		1105 S. Schumake	r Dr., Apt	t. 10	9	21804				-	SA	outiny:
	na 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Was Decedent of H	ispanic Origin	n? (Specify	y Yes or No	-	14. Race - Ame	
0	after or itel	Fü	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯		}	f Yes, specify Cubi		Puerto Ric	an, etc.)		Black, Whi	
3	rai', c	1 by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☒ No	Specify:				Specify: V	white
ဂ ဂ	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	tent's Usual Occup	during most o	of working		16b. Ki	nd of Business	/Industry
7	within ne. hen	ldm	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT use retired	3)			NBC	Broadca	astina
7	iled v tygle ther t nt, in		12 17. Father's Name (First, Middle, Last)	2		Seci	etary	18. Mother's	Name /F	1			-502119
מום	od of	Be	Herbert Hayes M					Eva 1			mardon	Obmamo,	
2	thoute d Me mark matic	2	19a. Informant's Name/Relationship (19b. Mailin	ng Address (Street				ar. City o	Town State	Zip Code)
<u> </u>	ith ar 27 is r trau		Cathy Clark/daugh	ter			0 Tunis				-		
กั	r Hea f Hea item other		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Name of natory or other place		Date			cation - City or	
Saltimor	Page ent o nt: If ry or		1 ☐ Burial 2 【A Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		-	•	Cremato		/14/0)5	Sal	isbury,	MD
	permit. Departminimporta any inju		21. Signature of Funeral Service Lice	s e	0								Association
מ	e o iii e d		Malt R K	ruly (3/		01 Snow						
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each li	the death								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	MASSI	VE	INTR	A CEREI	BRAL	H	EMOR	RH	AGE	Onset and Death DAY
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
	LAGIIIIIei	L ,	Sequentially list conditions,	b									
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	s be executed sicien and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):							
9	sicier sicier s buri			d									
000	g phy as th	Physiclan/Medical											
X O O	h cer endin	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnancy				2	3d. Date of de	
ם 5	deat	sicle	in the past 12 months? 1 ☐ Yes 2 🗹 No	4☐Pregnant at			Other (specify)					Month	Day Year
	at the	Phy	9 Unknown			dati e di e alecci	4 1	- 1: D - 11	-	oo- Bida			
ń	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the I		Part II. Dther significant conditions of HYPERTENS		ut not resu	aing in the ur	nderlying cause giv	en in Paπ I.					o the cause of death? robably 4 □Unknown
cords,	requ	etec	ATRIAL F.		TIAC	SI.			-				
ည	has t	Completed by	HIRIHL F	13/21201	1101				-	24a. Was autop		24b. Were at prior to death?	utopsy findings available completion of cause of
5	r: Th icate r, pag									1□ Yes	2 🔀 No		2 □ No
VIIdi	Physician: The law this certificate has b ral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	- 00	-D/O 4	t all Doa Oth	26. Place of					
5	r this	-	27. Manner of Death	28a. Date of Inju (Month, Da		ER/Outpation 28b. Time of	JU DON	4 🗆 Nuisi		I. Describe h	·	Other (Spe	city)
5	tending leath. tor: After the funer	atlor	1 ☒Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury		k? Yes 2∐No					
DIVISION OF	Atter or dea ector by the	iffica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At hor	me, farm, stre	eet, factory, office		28f.	Location (S City or Tow	Street and	d Number or Ri	ural Route Number,
5	s afte si Dir ed in	Certification:	4 Homedo	building, et	c. (Specify,	/				Only or You	m, State)		
	To the Hospital or Attending Physician: while 24 hours after deals as a feet deals To the Funeral Director: After this certified completely litled in by the funeral director; is	edical	29a. Certifier 1 Certifying Ph	ysician: To the best	of my knov f examinati	vledge, death	occurred at the tir	ne, date and p	place, and	due to the d	cause(s)	and manner as	s stated.
	the hin 24 the F	Medi	one)	and manner sta									
	To To	-	29b. Signature and title of certifier	Yen	En	, M.	29c. Licens		69			signed (Mont . R いAR	14 14, 2005
	03							7	-		, 0,		
	100		M. SHIRAZI, M.	D. PENIA	JSUL	A RE	GIONAL	MED	ICAL	CEN	TER	. MI	21801
	Sta Registr		31. Date filed (Month, Day, Year) FEB 16 2	005 32. Augistra	ars Signat	& A	mete						

			1- For Amend Item	25 per Dr.,	lanylan G842,	d/Depa ,04/08	artment o	of He	alth a	and Mer	ntal Hyg	iene	2005	. 0	775 485
			Registrar 1. Decedent's Name (First, Middle				imouto (0, 0			Date of Deat	th	- // //	3. Time	of Death
	Physici /Medic		Samuel	С		Cui	ry			Fe	Month bruary	7 11	, 2005	7:00	Ам
	Examin		4a. Facility Name (If not institution) Washington Adve				4b. City, Tow Takoma	,		f Death		1	county of Deat		
	Funeral Director		5. Social Security Number 067–28–7160	6. Sex 7. A	ge (In yrs.	last birthday) 8 Yrs.	If Under 1 Y Months Da		If Under 2 Hours	rebri	Date of Birth (Month, Day Jary	0°, 1′9	37 Wasl	hplace (State buntry) hingto	_
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
	Mary 1 sho	ţō	Maryland Prince	Georges	Lan	dover								1 X Ye	es 2 □ No
	h the	Director	10e. Street and Number		1		10f. Zip Co	de			1	0g. Citiz	en of What Co	untry?	
	23a c		510 Hill Road				2078	85				USA	<u> </u>		
36	I within 72 hours after death with the Maryland jiane. Jibe Me Jical Erat: it with the Incillist and Its Me Jical Erat: it with the Incillist and	by Funerai	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ied 1\(\) Yes 2 \(\) If Yes, Give Year or Dates:	? No		Was Decedent If Yes, specify (1 ☐ Yes 2⁄⁄⁄⁄⁄⁄⁄⁄	Cuban,					4. Race - Ame Black, White Specify: Bl.	e, etc.	
9	"natural",		15. Decedent	's Education	1,,,,	16a. Dece	dent's Usual O						d of Business/		
21215-0036	c = 3	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work de DO NOT use re	one dur etired)	ng most	ot working	Į,	7a L a w	ana IIo		
21	filed withir I Hygiene. other then	Co	12			Super	visor		0.11.11.	4. 1			ans Ho	sprtar	·
Maryland	d a b	Be	17. Father's Name (First, Middle, I Unknown	_ast)				18		rs Name <i>(Fi</i> CNOWN	irst, Middle, I	Waiden S	iumame)		
2	s fand 2 should ba f Health and Mental H item 27 Is marked of othar traumatic eve	은	19a. Informant's Name/Relationsh	nio (Type, Print)		19b. Maili	ng Address (St	reet and			oute Number	. City or	Town. State. Z	Zin Code)	
S	24 F 2		Donnell Curry/			3	Pyle Co					-			
ē,	is 1 and 2 of Health item 27 other tra	10	20a. Method of Disposition		1 6	Place of Dispo	sition (Name of matory or other	of	- 1	Date	-		ation - City or		
E	Page nent o int: If iry or		1 Burial 2 Cremation 1 Other (S _i		• L		ns Cem.		1	2/22/	05	Che1	tenham	, Mary	land
Baltimore,	parmit. Pages 1 a Department of He Important: If item any injury or othe		21. Signature of Funeral Service I	Licensee	MO13		2. Name and A		_ `		A. Aqu	asco	, Mary	land	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the deat									Approxima Interval Be	etween
	Physician	8 0	Immediate Cause (Final disease or condition	MALIC	NEN	UT C	ARDIA	1C	AG	28 H	ITHO	nIA		Onset and	1 Death
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	rted nsit	nine	cause. Enter Underlying Cause (Disease or injury	` `	ITE	<u> </u>	JP14	D A	TA	PV		- 01	LUR	no.	
ć	axecun and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or a	s a conseq	uence of):		3 4	, , 0	12					
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9	The law requires that the death certificate be axecuted ate has been signed by the attending physician and bage 2 should be detached for use as the burlal-transit	0	IF FEMALE:			7						1			
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0.	at the dea by the a tached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	eath 5	Other (specify	y)						,	
<u>α</u>	that the		Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying cause	e given	in Part I.		23e. Did tob	acco us	e contribute to	the cause of	death?
Records,	uires sign	d by								_	1 □ Ye	s 2 🗆	No 3□Pro	obably 4 🗷	gUnknown
S	w requir been si should	Completed									24a. Wasa		24b. Were au	topsy finding	s available
	The la	mo.									autops perform 1 Yes 2	y ned? 2 ⋌ No	death?	completion of 2 \(\subseteq \text{No}	cause of
ital		0	25. Was case referred to medical					2	26. Place	of Death (C	heck only on		12,163	20110	
☆	nysica iis ce I direc	To B	examiner? 12 Yo s 2∑ No	Hospital: 1 Minpat	ient 2 🗆	ER/Outpatier	nt 3 DOA	Other:	4 □ Nui	rsing Home	5 🗌 Reside	ence 6	Other (Spec	cify)	
Sho	ng Ph After thi Ineral		27. Manner of Death 1 X Natural 5 ☐ Pendin	28a. Date of Ing (Month, D	ury ay Yea <i>r)</i>	28b. Time o Injury		Injury a Work?			Describe ho	w injury	occurred		
<u>S</u>	Attending Physician: r death. ector: After this certific. by the funeral director,	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be					s 2 🗆 h		Lanction /St		Mumbas as Du	sa (Pausa Atu	
Division	or At after of Direction by	Certification:	4 Homicide determ	ined 286. Place of II	atc. (Specif	y)	eet, factory, of	TICE		201.	City or Towr		Number or Ru	rai moute ivui	mber,
	e Hospital or Attending I 24 hours after death. e Funeral Director: After etely filled in by the funer	edical Co		g Physician: To the bes Examiner: On the basis and manner s	of examina										(s)
	To the Hos within 24 hr To the Fur completely	Me	29b. Signature and title of certifier	r	/	,	29c. Li	cense n	number		2	9d. Date	signed (Month	, Day, Year)	
	,- > F 0		> Chandre	1ekhor \$	Congre	Zas.	DMI	> 5	28	55		02	-13-	05	
			30. Name and address of person	who completed cause of	death (Iten	n 23a) (Type,									10000
			DR. CHANDRA	KORAP	ATI	72	Print) 07 HA	NOV	IER.	PKW	v G	REE	NBELT,	Md.	:0110
	Sta Registi		31. Date filed (Month, Day, Year)	6 2005 32. Rojis	trar's Signa	ature ,	fork								

			1 - For State Registrar	State of N	Maryland / De C	partment of F ertificate of		-	giene Reg. No.	05	06877
			1. Decedent's Name (First, Middle,	Last)				2. Date of De	ath		3. Time of Death
	Physici /Medio		Evadne	Campbe	e11			Month February	13, 200	Year 15	3:35 P M
	Examir		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of De	ath	4c. Cou	nty of Death	
			Kensington Nurs			Kensi				ontgom	
	Funeral			1. Sex 7 1 □ M 2√2 F	Age (In yrs. last birthd	Months Days		in. (Month, Da			place (State or Foreign ntry)
	Director		578-72-1446 Usual Residence of Decedent	- 4	90 '''			Oct.7,	1914	Jama	ica
	/land		10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits
	Man,	tor	Maryland Montg	omerv	K	ensington					1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	1th will	ai	3000 McComas Av	enue		20	0895		US	SA	
	Items	Funerai	11. Marital Status	12. Was Deceder Armed Force		Was Decedent of If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	0- 14. F	Race - Americ Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	d 1 □ Yes 2 [If Yes, Give Year or Date:		1 ☐ Yes 2 🖾 No	Specify:		Spe		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "netural", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	ed	15. Decedent's			cedent's Usual Occur	pation		16b. Kind of	BLa Business/In	ack
215	n nedi	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	(G	ive kind of work done e. DO NOT use retire	during most of v	vorking			,
21	e filed within al Hygiene. I other then "	Completed	9	0011090 (1 40		ekeeper			Housek	ceepin	g
pu	al Hygie d other	Be (17. Father's Name (First, Middle, La	ast)			18. Mother's N	iame (First, Middle	, Maiden Sum	ame)	
yla	2 should be I and Mental I is marked o	ပ္	Unknown				Unkn				
Nar	2 sh and is m		19a. Informant's Name/Relationshi			ailing Address (Street					,
di.	s 1 and 2 should of Health and Meritem 27 is marke other treumatic		Eliza Angelina 20a. Method of Disposition	Scott Ni	20b. Place of Di	1 Leonard		Silver S	ring M 20c. Locatio	<u>laryla</u> o - City or To	nd 20910
و	Se i de		1 ☐ Burial 2 ত্ৰিCremation 3		cemeten/	rematory or other pla	ļ.				
Baltimore,	artmer artant ortant njury		 4 □ Donation 5 □ Other (Special Service Line) 21. Signature of Funeral Service Line 			_Crematory	Feb	.14,2005	Alexan	dria,V	/irginia
Ba	permit. Pages 1 Department of H Important: If ite any injury or ott	l) d	Q. Ko. 51/10			Francis J.	. Collin	s Funeral	1 Home,	Inc.	MD 20001
			23a. Part1. Enter the disease, or c	omplications that caus	sed the death. Do not	500 Univer				pring	Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		umonia as a consequence of):						Sudden
	Examiner		Sequentially list conditions.	b							
	D #	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of					- 1	
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):						
8760,	be ey				20						
687	ficate physics the t	edicai		d							
Вох	death certifica attending ph of for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		0.05			23d. I	Date of delive	ery
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	У		1	Month	Day Year
P.0	that the de led by the detached	hys	9 🗆 Unknown								
Ś	es thaigned	þ	Part II. Other significant condition	s contributing to death	n but not resulting in th	e underlying cause gr	ven in Part I.				he cause of death?
Records,	w requir been si should I	Completed	Dementia		· · · · · · · · · · · · · · · · · · ·			-			pably 4 Unknown
Sec	e law has b	npie						24a. Was	an 24! psy ormed?	 b. Were auto prior to cor death? 	ppsy findings available mpletion of cause of
								1 ☐ Yes	2 XNo	1 Yes	2□ No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Cti		Death (Check only			_
of		⊢ :	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of I	njury 28b. Tim	e of 28c. Inju	ry at	g Home 5 Resi			y)
OU	Attending For death. ector: After by the funera	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	(Month, i	Day Year) Inju	y Wo	rk?]Yes 2 □ No				
Division	4 - 9 9	iffice	3 Suicide 6 Could no 4 Homicide determin	286. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (City or To	Street and Nui	mber or Rurz	al Route Number,
Ö		Certification:		balloling,	etc. (Opecny)			0.1y 0.7 7 0	·····, Claicy		
	하는 하는 등	Medical			st of my knowledge, d s of examination and/o stated.						
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year)
	1)	7	M	2 D 5	53528	1	Februar	v 14.	2005
	,		30. Name and ad person w	ho completed cause o	of death (Item 23a) (Ty		.5520	-0-	- CDI dai	ámilio.	1003
			Daphna Henkin,		09 Shorefi		Wheato	n,Maryla	nd 209	02	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 15	2005 32 legi	strar's Signature	parle					

Physician Melvin Charles Crampton Melvin Charles Crampton Melvin Charles Crampton Melvin Charles Crampton Melvin Charles County of Death Melvin Charles Melvin C			For State Registrar	ype or Print in t State of Marylar	nd / Depa		lealth and M	ental Hygi	•	0687
## Construction Security Number Construction of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location of Departs As Capty Term, or Location Association •			Crampton				Month	Day Year	3. Time of Death	
Use A Placetorized of December Tool, Inside Company Tool (Inside	Examir		Washington Count 5. Social Security Number 6. Sex	y Hospital 7. Age (In yrs.	last birthday)	Hac If Under 1 Year	erstown	8. Date of Birth	Wash	ington
Elementary/Secondary (0 12) College (1-for 5+) Concrete Finisher Construction Concrete Finisher Concrete	Director		220-09-8180 Usuel Residence of Decedent				Hours Min.	Sept.21,	1919	Maryland
Elementary/Georodary (0-12) College (1-for 5-) Concrete Finisher Construction	he Maryla 18a-f shov offilied at	ector	Maryland Washing			narpsburg]			1 □ Yes 2X
Bermaniany/Georatidary (9-12) College (14-of 5-) Concrete Finisher Construction	sath with t	erai Dir	3641 Harpers Fe	erry Road	10				U	SA
Bernariany/Geometry (9-12) College (1-4or 5-) Concrete Finisher Construction	ursafterd ai', or item Examina	by Fun	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No 19	42-			Rican, etc.)	Black, Whi	te, etc.
Secretary Secr	ithin 72 ho ne. han "netur s Wedical	npieted	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of workir d)	ng 1		/Industry
Second S	l be filed w ntal Hygier ed other ti event, th	Be			Co	oncrete F	18. Mother's Name		faiden Sumame)	ruction
Section Comment Comm	12 should h and Mer 7 is marke raumatic	7	19a. Informant's Name/Relationship (Typ	ре, Print)	19b. Mailir	ng Address (Street				Zip Code)
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the underlying cause given in Part I. 1	Physician /Medical Examiner periodical periodical periodical periodical	ä	23a. Part1. En ir the disease, or complice shock, heart failure. List only on Immediate ause (Final disease of condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consecutive to (or a))).	th. Do not ent Luck quence of): Luck quence of):	25 S. Cor	ococheagu	e St. Wi		Approximate Interval Between Onset and Death
25. Was case referred to medical examiner? 1 Yes 2 No	the death certifica y the attending plached for use as t	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3		y			
25. Was case referred to medical examiner? 1 Yes 2 No	quires that in signed b uld be deta	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.			,
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of eath Mospital: Inpatient 2 EP/Outpatient 3 DOA 28. Time of Injury at work? 1 Yes 2 No 28. Time of Injury at work? 1 Yes 2 No 28. Time of Injury at work? 1 Yes 2 No 28. Place of Injury At home, farm, street, factory, office 28. Location (Street and Number or Rural Route Number of N	The law re ate has bee	omplet						autopsy perform	iegd? death?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ician: certifica rector,	Be	examiner?	ospital: 2		O++	er	(Check only one	9)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	iding Phys th. : After this stuneral di	H	27. Manner of eath 1 Natural 5 Pending	28a. The of Injury	28b. Time of	28c. Injui	y at 2			city)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	al or Atter s after dea il Director ad in by the	Sertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, office	2			ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	he Hospit in 24 hour he Funers oletely fille		(Check only /2 Medical Examin	er: On the basis of examina	owledge, deatl ation and/or in	n occurred at the til vestigation, in my o	me, date and place, a ppinion, death occurre	and due to the car and at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
HO+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kleylys wille	To t with To t	2	29b. Signature and title of certifier					29	2 4 2	
The state of the s	HO+1		30. Name and address of person who con	mpleted cause of death (Iter	т 23а) (Туре,	Print)	dysville	Ad	21756	

Amended #20c, nls, 02/18/05, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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f Maryland / Department of Health and Mental Hygiene

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EF	R FH	•	1 - For State Registrar		State of IV	iaryiano	Cei	rtificate of	Death	wental H	ygien Reg. N		068	1
	Physici		1. Decedent's Name (Fi		ARR				-	2. Date of D Month FEBRUA	D	Day Year 17 2005	3. Time of Dea 0450	th N
	/Medic Examir		4a. Fecility Name (If not			-)	-	4b. City, Town, o	or Location of Deat			lc. County of Dea		
b	LAUIIII		Memorial H	ospital				Cumber1	and		1	Allegany		
	Funeral		5. Social Security Numb	per 6. Se	9x 7. A	ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Birth Day, Yea	9. Bir	thpiace (State or For	eigi
ŀ	Director		234-46-697	6	□ M 2XXF	75	Yrs.			JUNE 2	23,	1929 WES	T VIRGINI	A
	and		Usuel Residence of Dec 10a. State 10	b. County		10c. City,	Town or Lo	cation					10d. Inside City Lie	mits
	Mary	ğ	wv	MINERA	L	RI	DGELE	Y					1 □ Yes 2X] No
	r 28a	Funeral Director	10e. Street and Number	r				10f. Zip Code			10g. C	Citizen of What Co	ountry?	
	h with	a D	ROUTE 3, B	OX 284				26753	3		τ	U.S.A.		
	ems ;	ner	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.S	. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No Rican, etc.)	No-	14. Race - Ame Black, Whit		
Maryland 21215-0036	72 hours after deeth with the Maryland "naturel", or Items 23e or 28e-f ehow idical Examiner must be invitted at	Ď	1 Never Married 3 Widowed 4		1 ☐ Yes 20 If Yes, Give Year or Dates:	₹No		1□Yes 2[X]No		,		Specify:	WHITE	
5-0	72 h	Completed		Decedent's Ed		4	(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b.	Kind of Business	/Industry	
121	yiene.	mp	Elementary/Seconda	ry (0-12)	College (1-4or	5+)		DO NOT use retire: MEMAKER	d)		,	HOME		
7	D (D)		17. Father's Name (Firs	st. Middle. Last)			1101	THEMILIN	18. Mother's Na	me (First, Middl				_
an	a la b	o Be	FRED M. SI							MARTI		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
<u></u>	2 should by and Menta le marked eumatic e	ို	19a. Informant's Name		ype, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ural Route Num	ber, City	or Town, State, 2	Zip Code)	_
	nd 2 alth a 27 le 27 le		TONY K. CA	RR, SR.	/ HUSBAN	ND D	ROU'	TE 3, BOX	7 284, RI	DGELEY	, WV	26753		
Baltimore,	Peges 1 and 2 should ent of Health and Mer nt: If item 27 le marke iry or other treumatic		20a. Method of Disposit 1 Durial 2 C 4 Donation 5	remation 3	Removal from State	cer	netery, crer	sition (Name of matory or other place EMETERY	ce) 02/2	Date 20/2005	20c.	Location - City or Dawson FAWSON,	Town, State	
Balti	permit. Pege Department of Importent: If eny injury of		21. Signature of Funera					Name and Addre	I FUNERAL	HOME,	P.A	•		
			23a. Part 1. Enter the d	isease, or comp	lications that cause	d the death.	Do not ent	202 GREI er the mode of dyir	ENE STREE	CUMI c or respiratory	3ERL/ arrest,	AND, MD	21502 Approximate	_
	Physician		shock, or heart fall Immediate Cause (Final disease or condition	ilure. List only o	a. SEPSIS	line.							Interval Between Onset and Death 10 DAYS	١
	/Medical Examiner		resulting in death)		Due to (or a	s a conseque	ence of):							
e.		<u>_</u>	Sequentially list conditi	ions,	b. Due to (or a:	s a conseque	ence of):							
	uted d ansit	Examiner	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injurithat initiated events	ng ry	,		·							
ó	ificate be executed g physicien and es the burial-transit	Exa	resulting in death) Last	- 1	Due to (or a	s a conseque	ence of):		·	•				
68760,	tte be ysicie	edicai		•	d									
	ntifica ng ph s es th		IF FEMALE:											_
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use es the burial-transit	Physician/N	23b. Was decedent pre in the past 12 mor 1 Yes 2 K No 9 Unknown	nths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	,			23d. Date of del Month	ivery Day Year	
ص.	that t		Part II. Other significer	nt conditions co	ontributing to death	but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death	?
ds	quires n sign uld be	d by	ANOXIC ENC	CEPHALOF	PATHY					1 🗆	Yes :	2 □ No 3 □ Pr	obably 4 Dunkno	own
Records,	law requir as been si 2 should	Completed								24a. Wa		24b. Were au	utopsy findings availa	able
æ	The la	mo									opsy formed?	death?		of
ita		0	25. Was case referred	to medical					26. Place of Dea			10 10195	2□ No	_
<u>></u>	S S	To B	examiner? 1 Tes 2 No		Hospital: 1 🛣 Inpat	ient 2 E	R/Outpatien	t 3 DOA Oth	05			6 ☐Other (Spe	city)	
Division of Vital	ding Pt h. After th funeral			☐ Pending investigation	28a. Date of Inj (Month, D	ury 2 ay Yeer)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how inj	ury occurred		
ivisi	or Attending after death. Director: After in by the fune	Certification;	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Ir	njury - At hom etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or To			ural Route Number,	
	Hospitel or 24 hours afte Funerel Dir letely filled in		29a. Certifier 1	Certifying Phy	sician: To the bes		ledge death	occurred at the tir	ne date and place				etated	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 one)	Medical Exam	iner: On the basis and manner s	of examination	on and/or in	vestigation, in my o	pinion, death occu	rred at the time	, date a	nd place, and due	to the cause(s)	
	To the Mithin 2.	2	29b. Signature and title	4 1	16			29c. Licens				ate signed (Monti		
7	3		P /	11	/WS)				33280		tel	17/2	605	
	nes		30. Name and address SUNIL GUP		completed cause of 625 KEN			Print) CUMBERLAI	ND,MD 215	502				
	Sta Registi		31. Date filed (Month, D	Day, Year) 1 8 200!	0.7	trar's Signatu	0	1.P. 3						
			V Reported	a d CUU.	· when	~ 4/		S. College						

DHMH 17 Rev 1/2001

Amended # 19b, MLU Allegany Co 02/17/05 1 - For State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Months

10f. Zip Code

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

CUMBERLAND

Under 1 Year If Under 24 Hrs. onths Days Hours Min.

06880

0540

9. Birthplace (State or Foreign

10d. Inside City Limits 1 TYYes 2 □ No

Maryland

	Physician
	/Medical
- 1	Examiner

PER FH

1. Decedent's Name (First, Middle, Last) Otis Thomas Cuppett, Jr.

1**⊠** M 2□ F

Allegany

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

Reg. No 2. Date of Death Month Yea **FEBRUARY** 15 2005

Date of Birth (Month, Day, Year) Jul. 15, 1925

4c. County of Death

10g. Citizen of What Country?

ALLEGANY

3. Time of Death

Pages 1 and 2 should be filed within 72 hours after death with the Nant of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural; or Items 23a or 28euny or other treumatic event, its Modest Exerginar

permit. Page Department of Importent: If any injury or once.

Priysician

/Medical

Examiner

burial-transit

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page 2 s has

director,

this After this

efter death. Director: A

24 hours e

To the within 2

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records.

the Hospitel or Attending Physiclen:

Baltimore, Maryland 21215-0036

/Medic Examin	
uneral rector	
8e-f show	ctor

Be

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5. Social Security Number 215-20-7418 Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number Dire Funeral 11 Marital Status Completed by

1 ☐ Never Married 2 X Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9

229 Baltimore Ave. 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No If Yes, Give Year or Dates: 1943-46

College (1-4or 5+)

7. Age (In vrs. last birthday)

10c. City, Town or Location

79

21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

Cumberland

USA 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian

County Government 18. Mother's Name (First, Middle, Maiden Surname)

Flintstone, MD

17. Father's Name (First, Middle, Last)

Otis Thomas Cuppett, Sr.

Iona M. (Kerns) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502

19a. Informant's Name/Relationship (Type, Print) Jean A. Cuppett/Wife 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cemetery

229 Baltimore Ave., Apt 909 Cumberland, MD - 502 Date 20c. Location - City or Town, State

2/17/05

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundial Service Licensee

1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

22. Name and Address of Facility

Kight Funeral Home

309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Approximate Interval Between Onset and Death

2 DAYS

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):

b. ACUTE RENAL FAILURE Due to (or as a consequence of)

CHPONIC RENAL FAILURE

1 WFEL

Due to (or as a consequence of):

YEARS

IF FEMALE

by Physician/Medical Examiner

Be Completed

Certification: To

Medical

23b. Was decedent pregnant in the past 12 months?

If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ILEUS

1 🗌 Yes	2□No	3 Probably	4 Unkn

24a. Was an autopsy performed? 1 ☐ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accider 5 Pending Accident investigation 6 ☐ Could not be 3 🗌 Suicide 4 Homicide

Hospital: 1 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of Injury

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 Tyes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one)

29a. Certifier

MD D0018216

29d. Date signed (Month, Day, Year) FEBRUARY 6 2005

ated cause of death (Item 23a) (Type, Print) 900 Section Dr Cumberland MO 21502

31. Date filed (Month, Day, Year)

Mercen & Sparle

State Registrar

3

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2005 14 9:45 Louis Copp February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Northampton Frederick If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) March 16,1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1**X**) M 2□ F Days Hours 711-01-0336 89 Kansás Director Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Completed by Funeral Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Items 23a or 21702 1020 Dulaney Mill Drive United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Conductor Railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William W. Copp Edith Cotton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Copp / Son 1020 Dulaney Mill Drive, Frederick, MD 21702 it of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. Mountain View Mem.Park 2/18/2005 Barstow, California * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Physician Chronie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year for 5 Other (specify) 4☐ Pregnant at time of death P.O. I 9 Unknown ģ signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 Yes certificate Yes tha Hospital or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide n 24 house Per Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2-14-05 MTolino MD 51610 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick mo Taner 31. Date filed (Month, Page Year)6 200t State Registrar

			For State	State of Maryland / I	•		ental Hyg	iene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of De		2. Date of Deat	ng. No. 2	05	3. Time of Death
П	Physicia	an		P. 200-	5.) Lieta		Month	Day	Year 05	1750 PM
	/Medic		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Lo	cation of Death	cd-	4c. County		(1301
	Examin	er	Peninsula Legional		Salis	hird		18/1	ONic	10
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit		Under 24 Hrs.	8. Date of Birth (Month, Day,			ice (State or Foreign
	Director		214-19-4713	M 250 84	Yrs.	IOUIS WIIII.	5-8-	- 20		mo
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10	d. Inside City Limits
	Aaryla sho	ō	masily am	50	LISBURY					1 Yes 2 □ No
	the A	Director	10e. Street and Number	ICO OF	10f. Zip Code	-	11	0g. Citizen of V	Vhat Count	ry?
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	death	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spec	cify Yes or No-		e - America k, White, e	
9	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, the Medical Evant art must be notified at		1 Never Married 2 Married	1 ☐ Yes 250 No If Yes, Give		Specify:		Specify	_	ACK
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7	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give kind of work done duri life. DO NOT use retired)		g	100. Killa of Bo	15111625711101	astry
712	filed withi Hygiene. other than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSEKEE	PER		ISHAN	1 FAI	MILY
	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)	HOUSEN INC		. Mother's Name	(First, Middle, M	Maiden Suman	ואיט (אי	there is
/lar	should be nd Mental marked c	ToE								
Maryland	and and series		19a. Informant's Name/Relationship (Typ	oe, Print) 19t	o. Mailing Address (Street and	Number or Rural	Route Number	, City or Town,	State, Zip (Code)
	permit. Pages 1 and 3 Department of Health Important: If itam 27 any injury or othar tr				8 - BAILEY L	ANE SAL	LIS BUEY	20c. Location -	SO/	un Stata
altimore,	Pages 1 nent of Hi int: If ital		20a. Method of Disposition Disposition 3 □Re	emoval from State	ery, crematory or other place)			200. Location -	City or Tov	M, State
Itim	tt. Partimentriant		 4 □ Donation 5 □ Other (Specify) 21. Signature of Filmoral Service License 	DT JAI	MES CHINACH CEN 22. Name and Address of		9/05	DNDW	HILL	1//0
Ba	permit. Departr Importa any inj		21. Signature of Pullball Service License	fal	The state of the s	00		5 SMI		14
7			23a. Part1. Enter the disease, is complete	ations that caused the death. Do	not enter the mode of dying, s			BURY, T		Approximate
	Physician		shock, or heart lilure. List only one Immediate Cause (Final	e cause on each line.	YOCARDIAL	INF	ARCT	100		Interval Between Onset and Death
	Physician /Medical	Н	disease or condition resulting in death)	Due to (or as a consequence		- 1	1001			4 110 000-3
	Examiner		Conventially list conditions							
	p =	Iner	Sequentially list conditions, cause. Enter Underlying	Due to for as a consequence	of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
60,	ficate be executed physician and is the burial-transit			546 to (51 45 4 551/354451100	31).					
68760	icate phys s the	edical	d.	•						
Box (certif nding use a		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy	.55			23d. Da	te of deliver	у
m̃.	that the death cert ed by the attending detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 Live birth 2 ☐ Fetal death	n 3 □Ectopic pregnancy 5 □ Other (specify)			Mo	nth (Day Year
P.0.	at the by th tache	hys	9 🗆 Unknown	9□ Unknown			400			
	es that the death certii igned by the attending be detached for use a	by	Part II. Other significant conditions con	tributing to death but not resulting VE HEART		in Part I.				e cause of death?
ord	w require been si	ted	CONGESTI	TO HERICI	1 11100		1 16	9S 2 1NO	3 <u> </u> F1008	LUIY 4 MOTIKITOWIT
ec	The law requires ate has been sign page 2 should be	Completed					24a. Was a autops perforr	SV I	Were autop prior to com death?	sy findings available pletion of cause of
a F							1☐ Yes 2	2⊠ No	1 ☐ Yes	2□ No
Z.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital: 1 ☐ Inpatient 2 ☑ ER/O	Other	6. Place of Death 4 Nursing Hon			or (Coosife	1
Division of Vital Records,	Phy r this ral d		27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at		8d. Describe ho			,
ion	Attanding r death. sctor: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		s 2 No				
Vis	after death Einactor:	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f	arm, street, factory, office	2	28f. Location (St City or Town	reet and Numb n, State)	er or Rural	Route Number,
Ö	rs after as Diva	Cerl		Ballaling, otor (openiny)						
	e Hospital or / 24 hours after e Funeral Dira etely filled in b	edical	(Check only 2 Medical Examin	ician: To the best of my knowledg ner: On the basis of examination a	ge, death occurred at the time, nd/or investigation, in my opin	date and place, a ion, death occurre	and due to the ca	ause(s) and ma ate and place,	anner as sta and due to	ited. the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License n	number	2	9d. Date signe	d (Month. D	Day, Year)
	S E S		250. Signature and title or certifier	7-1	7) 4	6962	- F	EBRUA	RY 1	1, 2005
7			30. Name and address of person who co.	moleted cause of death (Item 23a)						
			M. SHIRAZI, A		LA REGIO	NALIM	EDICA	IL CEN	IER.	MD 21801
	St	ate	31. Date filed (Month, Day, Year) FEB 15 200	32. degistrar's Signature	1. 4.					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 5 06883 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JEAN K. CUMMINGS Feb 15 2005 6:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis ElderCare - The Pines Easton Talbot If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JAN 3 1923 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Hours Min 1□M 2₹F Months Days MARYLÁND 82 **Director** 214-12-6253 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinet must be notified at X□Yes 2□No MD Director TALBOT TILGHMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5934 MAIN STREET 21671 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be 1 and Mental } J. EARL WOTHERS BEULAH TRAVERS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 WILLIAM E. CUMMINGS/HUSBAND PO BOX 13, TILGHMAN, MD 21671 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Pages Department of Importent: If it any injury or o ō * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 2-16-2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shermer's dementer Immediate Cause (Final **Physician** rears disease or condition resulting in death) /Medical Due to (er as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown requires that the signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hox disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law autopsy performed 2 No Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 No Wanter S □ Residence 6 □ Other (Specify) 2 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After T Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7.16.05 ron 30. Name and address of person who completed cause of death (Mem 23a) (Type, Print) MD 610 CHMANS LROWLLY

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 7 2005

32. egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Пау Month **Physician** February 9 Frederick 2005 Eugene Cunningham 10:15 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 52 Edwards Lane Lothian Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1XM 2□F Yrs. Director 578-54-8254 63 Wash., D.C. Feb 5, 1942 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Bhow r than "natural", or Itema 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director MD Calvert North Beach 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8924 Greenwood Avenue 20714 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: \$ 3 Widowed 4 Divorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) plumber private university 8 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit iment of Heelth and Mental H tant: If Item 27 Is marked off Townsend Jack Harper Dorothy Mae ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Heelth a : If Item 27 is or other tra Toni Jo Emelio/Friend P.O. Box 161, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Southern Memorial Gar. 2-14-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Dunkirk, MD 21. Signatule d 22. Name and Address of Facility peral Service License (E Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Les Olvator /Medical Due to (or as a consequence of): Examiner Zethic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No detached the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes 2 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: friend's 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) P 1 Inpatient 3□ DOA residence 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/65 10 of person who completed cause of death (Illam 23a) (Type, Print) 30. Name and address Raymon A. Noble, M.D., 32 Cox Rd., Huntingtown, MD 20639 32. Registres Signature 31. Date filed (Month, Day, Year) State FEB 14 2005▶ Registrar

DHMH 17 Rev 1/2001

State Registrar

	•	State of Maryla State of Maryla State of Maryla Registra MEND#8per:INF2/18/05,BWW,McCo		artment of Health a		ene 005	06886					
Physic		1. Decedent's Name (First, Middle, Last) Sara de Cadena			2. Date of Death Month Feb.	Day Year 12 2005	3. Time of Death 12:55 p M					
/Medi Exami		4a. Facility Name (If not institution, give street and number) 10828 Childs Street		4b. City, Town, or Location o	f Death	4c. County of Death	n					
Funeral Director		458-57-8134 ^{1□M 2} ĀF 93	s. last birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. June of Birth June 15 25		nplace (State or Foreign untry) lombia					
72 hours after death with the Maryland natural; or Items 23a or 28a-f show deal Examinat must be reallisted at	Director	Maryland Montgomery	City, Town or Lo	ilver Spring			10d. Inside City Limits 1 ☐ Yes 2 XNo					
s 23a or 2	rai Dir	10828 Childs Street		10f. Zip Code 20901		10g. Citizen of What Country? Colombia						
ours after de ral', or Item Examinar	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican 1 X Yes 2 □ No Specify:	Colombian	14. Race - Amer Black, White Specify:							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at the Intelligible and ponce.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1 2	of working 1	6b. Kind of Business/I Own Home	ndustry							
uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Felix Joaquin Mantilla			r's Name <i>(First, Middl</i> e, <i>M</i> Antonia Man	laiden Surname)	antilla					
and 2 sho ealth and h m 27 is me		19a. Informant's Name/Relationship (Type, Print) Gloria M. Thomas/ Daughter	10828	ng Address (Street and Numbe 3 Childs Street	t, Silver Sp	ring, MD 2	0901					
permit. Pages 1 are Department of Heal mportant: If item into Injury or other page.		1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crei [etropol	osition (Name of matory or other place) Litan Crematory	2/13/2005		, Virginia					
permit Depar Impor any in	6	21. Signature of Funeral Service Licensee 23a. Part 1. anter the disease, or complications that causal the de	50	2. Name and Address of Facility 00 University I	Blvd. West,	Silver Spr						
Pnysician /Medical		shock, or heart failure. List only one cause on each line.	ive Hear	rt Failure	and or respiratory and		Interval Between Onset and Death Years					
cate be executed whysician and the burial-transit	dical Examiner	Sequentially list ou ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Pulmonary Edema Due to (or as a consequence of): C. Due to (or as a consequence of): d.										
ne death certifii the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year					
w requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but not re	esulting in the u	underlying cause given in Part I.		acco use contribute to	the cause of death?					
(0	Completed				24a. Was an autopsy perform	prior to co	topsy findings availabl ompletion of cause of 2 □ No					
Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	ER/Outpatier 28b. Time o	nt 3 DOA Other: 4 Nu	26. Place of Death (Check only one) her: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ry at							
Dir	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, str	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,					
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Check only 2 Medical Examiner: On the basis of examinand manner stated.		nvestigation, in my opinion, deal	th occurred at the time, da	te and place, and due	to the cause(s)					
To with	×	29b. Signature and title of certifier Cotta A huce colors	2001	29c. License number D06959		eburary 12						
	0		Hidden 1	Hill Lane, Pot	omac, Maryla	nd 20854						
Si Reg is	ate trar	31. Date filed (Month, Day, Year) 32. Jegistrar's Sig	S A	parle								

			For State Registrar	State of Ma	-	artmen ertificat			nd Me		giene Reg. No:	005	06887	
	Physici /Medic		Decedent's Name (First, Middle, Last Louise Den							Date of Dea Month 'ebruar	Day	Year 2005	3. Time of Death 12:57 A. ^M	
	Examir		4a. Facility Name (If not institution, give Shady Grove Advent	ist Hospit		Rocv	ille				Мо	ounty of Death ontgome:	ry	
	Funeral Director		5. Social Security Number 6. Se 578-07-5375 Usual Residence of Decedent	x	(In yrs. last birthday 92 Yrs.	Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day Cotembe	, Year)	Col	place (State or Foreign untry) ashington, D.C	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show Ita Mailgal Examili et mat Le maiffed at	Funeral Director	10a. State 10b. County Maryland Montgome 10e. Street and Number 401 Russell Avenue	ry	10c. City, Town or l Gaither		Code	20877			10d. Inside Cit 1 Tay'es 10g. Citizen of What Country? United States			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or Items 23a or 28a-f show may joury open traumatic evant, the Marical Examinet must be notified at an once.	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evarmed Forces? 1 Yes 2 Not If Yes, Give Year or Dates:	ver in U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba		n? (Specif Puerto Ric	y Yes or No- can, etc.)	14	4. Race - Amer Black, White Specify: Whi	ican Indian, , etc.	
21215-0036	within 72 ho lene. than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	al Occupa ink done d se retired,	lurina most o	f working		d of Business/I nking	ndustry					
Baltimore, Maryland 2	uld be filed Mental Hygi arked othar atic evant, 1	e	17. Father's Name (First, Middle, Last)	0 enison	Cle		44	Anna	Mil		Maiden S	lumame)		
	t and 2 sho fealth and t im 27 is me ther traums		19a. Informant's Name/Relationship (T) Dorothy Roach/ Siz		20h Place of Disr	neition /Nar	ne of		Date			Town, State, Z		
	permit. Pages 1 Department of H Important: If its any injury ocot		1 ☐ Burial 2 ☐ Cremation 3 ☐ the strict of		Geo. Was	matory or o h. Un Cente	ther place IVET: T nd Addres	s of Facility	brua; 200. Colum	y 7 5 mbia Mo	Wasl ortua	hingtor hingtor ary Ser on, D.C		
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	he death. Do not en		le of dying	g, such as ca	rdiac or r				Approximate Interval Between Onset and Death	
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):	ry d	isec	120	•				y-ears	
P.O. Box 68	death certific e attending p ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Petal death 3	□Ectopic pr □ Other (sp					23	3d. Date of deli Month	very Day Year	
	se us	by	Part II. Other significant conditions co	_	not resulting in the	, -		en in Part I.		23e. Did to			the cause of death?	
Records,	e law has t je 2 s	Completed	Aortic Stenosis Hyperlipidernia						_	24a. Whas a autops perform	sy	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of	
of Vital	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yo} \)	Hospital:				er: 4 🗌 Nursi	ing Home	Check only or	ence 6	Other (Spec	ify)	
Division of	or Attanding ifter death. Diractor: After in by the fune	Certification:	27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide Homicide 28a. Date of Injury 2 Packet of Injury 48b. Time of Injury 4 Nonth, Day Year 28b. Time of Injury 4 Nonth, Day Year 28b. Time of Injury at Work? 1 Yes 28c. Place of Injury - At home, farm, street, factory, office								treet and		ral Route Number,	
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner state	examination and/or i	ith occurred nvestigation	at the tim	e, date and pointion, death	olace, and occurred	due to the c at the time, d	ause(s) a late and p	nd manner as place, and due	stated. to the cause(s)	
)	To the within To the comple	Me	29b. Signature and title of certifler P.Callaba.				D C	number 117-94	1	2	Pebro	signed (Month	Day, Year) 2005 20879	
	,		30. Name and address of person who con the Callahan	lov wo	911 Ru	SSE 11	Ave		60	itters	burg	mo	20879	
	Sta Regist		FFB 1 4 201	32 Registrar	S Signature	ale								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 15, Robert Edwin Drennan, Jr. 2005 10:45 February /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Upper Marlboro 3212 Marcando Lane If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F 65 Director 284-36-5272 15, 1939 Ohió June Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Department of Health and Mental Hygiene. Important: If item 27 is markad other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 3212 Marcando Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ZYes 2 No7/3/57within 72 hours after 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2000 þ If Yes, Give Year or Dates: Specify: Specify: White 6/30/61 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Marriage Family Counselor Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Robert Edward Drennan, Sr. Inez Louise Jeffers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 Marcando Lane, Upper Marlboro, MD 20774 Eloise Drennan, Wife altimore, 20b. Place of Disposition (Name of Mary Tand National Park 20a. Method of Disposition 20c. Location - City or Town, State 1 SBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) 2/21/05 Laurel, Maryland 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility Northern Virginia Funeral Services 14522L Lee Rd., Chantilly, Virgini Richard D. Fitzgerald Virginia 20151 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 100 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Energy Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t rector, page 2 s autopsy performed? (es 25 No 2□ No 1 ☐ Yes 1 TYes or Attending Physician: 25. Was case referred to medical examiner? uneral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after decreal Director; After 1 Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 54400 February 16, 2005 30. Name in ordress of person who completed cause of death (Item 23a) (Type, Print) 4175 North Hanson Court, Suite 203, Bowie, MD 20716 Andrew Dobin, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Year **Physician** 5:00 P M Emily F. DeAtley Feb. 15, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Bethesda Bethesda Montgomery 5. Social Security Number 579 • 60 • 6034 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25, 1 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 104 Director 1900 Washington DC Usual Residence of Decedent the Maryfand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene. sant of Health and Mental Hyglene. sant: If item 27 is marked other than "natural", or items 23e or 28e-4 show ury or other traumatic event. If we wished Extra inter intal be notified at MD M∏Yes 2 ☐ No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9601 Parkwood Dr. Funeral 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Veterans Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin DeAtley ပ Emma Mehrling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau ODG. Paula S. Gregg / Neice 11280 Panorama Dr., New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Ft. Lincoln 1X Burial 2 ☐ Cremation 3 ☐ Removal from State feb.19,05 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawlers Sons, Inc. 21. Signature of Funeral Service Licensee MO1378 5130 Wisconsin Ave. N.W., Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 X No Month Day 4□Pregnant at time of death 5 Other (specify) detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy 1 Tes 2 🗆 No 2**X** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Thomicide 24 hours Funeral 29a, Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17141 D0055644 Feb. 16. 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.

State Registrar

FEB 1 7 2005

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb. 11, 2005 Rice Dameron 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Route 301 and Cherry Lane LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Birthplace (State or Foreign Country) Days 1 □ M 25 F Director 218-12-9849 85 May 10.1919 Maryland Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked othar than "neturel", or items 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked othar than "neturel", or itams 23s or 28s -f shov traumatic evant. Its Modical Examinational be notified at 1 ☐ Yes 2 ☑ No Director Bel Alton MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9050 Fairgrounds Road 20611 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Rice Catherine Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 412 Bel Alton, MD 20611 Sandra Pitrelli/ niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important: if ita any injury or oth 20a. Method of Disposition 20c. Location · City or Town, State St. Ignatius Cemetery 2/16/2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Port Tobacco, MD 21. Signature of Funeral Sovice Licensee M 0945 22. Name and Address of Facility
Arehart-Echols Funeral Home P.A.
P.O. Box 567 La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mult. Ple disease or condition resulting in death) injunes /Medical Due to (or as *consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has t certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∰Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury motoriched Accedent 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2-11-05 5:38 AM 2 Accident investigation 24 hours after death e Funaral Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Loud waf 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide R+301 + Cherzylons 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/13/05 1 aun Tegouri MO D-50883

Registrar DHMH 17 Rev 1/2001

mP10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11655 Winesap Pl. LaPlata, MD 20646

32. Registrar's Signature

n	Dameron		5	State of Ma	ryland / Dep	artment of	Health a	and Mer	ntal Hyg	iene	t
		•	State Registrar		Ce	rtificate o	f Death			CUU.oH.ge	06891
	Physicia	an	Decedent's Name (First, Middle,	•					Date of Deat Month	$\simeq 11, 200$	3. Time of Death
	/Medic	al .	John Edward I 4a. Facility Name (If not institution,			4b. City, Town,	or Location o		ebruai	4c. County of D	
	Examin	er	Route 301 and C			-	lata) Dodin		Charles	
	Funeral		5. Social Security Number 6	45714 OF E	(In yrs. last birthday	If Under 1 Yea Months Day		24 Hrs. 8. Min.	Date of Birth (Month, Day,	9. E 9. 1913 M	Birthplace (State or Foreign Country)
	Director		219-16-0980 Usual Residence of Decedent	9	1 Yrs.			Ju	ine 26	,1913 M	aryland
	/land		10a. State 10b. County		10c. City, Town or L	ocation		·			10d. Inside City Limits
	r 28e-f show	ctor	MD Charle	es	Bel Al	ton					1 ☐ Yes 2 🛣 No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code	•			0g. Citizen of What	Country?
	eath with	eral	9050 Fairgrour	nds Road 12. Was Decedent B	Ever in U.S. 13.	20611 Was Decedent of If Yes, specify Cu	f Hispanic Orio	gin? (Specify		USA 14. Race - A	merican Indian,
မွ	after d or Itan reiner		1 ☐ Never Married 2X Marrie	Armed Forces?	io	If Yes, specify Cu 1 ☐ Yes 3€ N			an, etc.)	Black, W	hite, etc.
003	co _ = 12	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates					1		hite
15-(n 72 hours "natural",	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Dece (Given life.	edent's Usual Occ e kind of work don DO NOT use reti	cupation ne during most ired)	t of working		16b. Kind of Busine	ss/Industry
212	swithing true.	omo	Elementary/Secondary (0-12)	College (1-4or 5	+)	chanic				U.S. Gov	vernment
nd	al Hyg d othe	Be	17. Father's Name (First, Middle, L							Maiden Sumame)	
Maryland 21215-0036	nould to Ment marks	ပို	John G. Dames		10h Mail	ina Address (Ctro			Dame	ron ; City or Town, State	Zin Codo)
E N	d 2 st than than treum		19a. Informant's Name/Relationshi Sandra Pitrell		1.4					MD 2061	
	1 ar Hea tam		20a. Method of Disposition		20b. Place of Disc			2/16/2		20c. Location - City	
DE L	it. Pages 1 and 2 should be filled within 72 hour rtment of Health and Mental Hygiene. rrtant: if itam 27 is markad other than "natural njury or othar treumetic avant, it a Modical Es		1 XBurial 2 ☐ Cremation : 1 4 ☐ Donation 5 ☐ Other (Sp.		St. Igna					ort Toba	acco, MD
Baltimore.	permit. Pages Department of Important: If i any injury or once.		21. Signature Fur eral Service L	M0094	5 Å	2. Name and Add renart O. Box	Echol	ls Fu	neral	Home, l	P.A.
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused nly one cause on each lin	the death. Do not er						Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	•	LE DINSU	ritz					Onset and Death
1	/Medical Examiner		resulting in death)		a consequence of):						
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Box (ath certifica attending ph for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnar	2014			23d. Date of	
	Hospitat or Attanding Physician: The law requires that the death certificate 44 hours after death. Funsel Diractor: After this certificate has been signed by the attending phately filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at		Other (specify)				Month	Day Year
PO	es that the de igned by the be detached	y Phy	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause	given in Part I.		23a. Did toi	bacco use contribute	to the cause of death?
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00	e law requ has been je 2 shoult	Completed							24a. Was a autops	sv prior	autopsy findings available to completion of cause of
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ion	ttanding I death. :tor: After r the funer	Certification:	1 Natural 5 Pending	ation 2-11-05	2 20		☐Yes 2 🖸	A 100			pair with a
Ž	or Att	rtiffic	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of injuried building, etc		treet, factory, offic	СӨ		City or Town	n, State)	Rural Route Number
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	the Hoshin 24 h tha Fut hpletely	Medical	(Check only 2 Medical E	xaminer: On the basis of	examination and/or i	nvestigation, in m	y opinion, dea	th occurred	at the time, d	ate and place, and	due to the cause(s)
	To the vithii To the comp	Σ	29b. Signature and title of certifier	1 . 1	14.0	29c. Lice	OCME			9d. Date signed (Mi	
			Mayine	me Inui	onth (ltc= 00=) T	- Print'				February	12, 2005
	mploti		YANUMUTO D	who completed cause of d		111 F	Penn St	reet I	Baltimo	ore, Mary	land 21201
	Sta		31. Date filed (Month, Day, Year)	5 2005 32. Registr	ar's Signature	1 4					
	Regist	rar	, 25 1		We to	good					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death ZUT 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12, 2005 ar **Physician** Feb. Dexter Elwood Dickerson, Sr. 4:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11877 Charles St. LaPlata Charles Lariala

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace Country) | Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) **X**M 2□F 227-36-3676 73 Director Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Nedical Evantrar must be notified at 1 Yes 2 No Director MD Charles LaPlata 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11877 Charles St. 20646 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1y☐Yes 2☐No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ ff Yes, Give Year or Dates Korean 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator LaPlata Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy W. Dickerson Ona Turman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11877 Charles St. La Plata, MD 20646 Iris Dickerson/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 (ment of F rtant: If it 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ŏ Department Important: If any injury or once. ^¹ 4 □Donation 5 □ Other (Specify) Monta Vista 2/19/2005 Galax Virginia 21. Signature of Funeral Service Licensee M00945 22. Name and Address of Facility Arehart-Echols Funeral Home P.O. Box 567 La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a donsequence of): Examiner Sequentially list conditions, if any, leading to immediate ease. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) law requires that the death certificate be executed burial-tran been signed by the attending physician and should be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes of or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 D Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral L the Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jule M D0001009 2-14-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burke, M.D. P.O. Box 2539 La Plata, MD 20646 154 Dr. Henry 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 5 2005

DHMH 17 Rev 1/200

Registrar

			For 1 State	State of	f Man	yland /	•					ental Hy	giene	209.0	- Com-	06899	2
			1 - State Registrar	1 11			Cei	rtificati	e or L	Jeatn		2. Date of De.	Reg. No	00	<u>J</u>	0007	_
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	/Medic	al	4a Facility Name (If not institution			rie D	ayho		Tours or	Location		Februar		1 200 County of		11:40a [^]	
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	s 23e	Funeral	301 Russell Ave				1)877				ted S			_
	er de Items	nue	11. Marital Status	12. Was Dec	orces?	er in U.S.	13.	Was Deced If Yes, spec	lent of His offy Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto i	cify Yes or No Rican, etc.)		14. Race - Black,			
5	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 🖾 Widowed 4 ☐ Divorced	ed 1 □Yes If Yes, G Year or [ve			1 🗆 Yes	2 🔯 No	Specify:			İ	Specify:	Whi	ite	
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7	d with	E	12	College	1-40/ 5+)			Secre	etary	7						County	
2	e file offie vent.	BeC	17. Father's Name (First, Middle, I	Last)						18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)			
<u> </u>	uld b Menta rrked ritc e	2	Milton Thompson	<u>. </u>						Pau1	ine I	King					
0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28a-f show is marked other then "neturel", or Items 23a or 28a-f show reumatic event. Ite Machical Examiner must be notified at		19a. Informant's Name/Relationsh	nip (Type, Print)		19	9b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	r, City o	r Town, Sta	ate, Zip	Code)	
., <u>.</u>	and sealth m 27		Tanya D. Grubb/	Daught						Cou		Concord					
ב כ	of H		20a. Method of Disposition 1	3 □Removal from		20b. Place ceme	of Dispo tery, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Lo	cation - Cit	y or To	wn, State	
	Pag ment ant:		`4 ☐ Donation 5 ☐ Other (Sp			Mt. O	_									Maryland	
Dallillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If item 27 is marked a therefrom "netural," or I tems 23a or 28a-f show any highry or other treumatic event. If a Marylad Examiner must be notified at once.		21. Signature of Funeral Service I	icensee		/	01	Name an	d Addres Mo I	s of Facilit Leswo	rth]	P. A Fu	nera	1 Hom	ie		
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			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cluse on	each line.	e death. D	o not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death	
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	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifyin	g Physician: To th	e best of n	ny knowled	ige, death	occurred	at the time	e, date an	d place, a	and due to the	cause(s)	and manne	er as st	ated.	
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	10		30. Name and address of person		-			Print)	\ \	1.	× / 0	1		1	_	9	
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			1 - For State Registrar	State	of Marylar	•	artmen rtificat					jiene	200	5	068	394
	Physici	an	Decedent's Name (First, Middle Victor, Honor, D.A.								2. Date of Dea Month	Day		ar	3. Time o	
	/Medic Examin	cal	repruary 13										2005 County of D	eath	11:35	р "
	Exami	lei	Holy Cross Hospi	-				ver S					Montgo	men	17	
	Funeral Director		5. Social Security Number	6. Sex 1★ M 2 F	7. Age (In yrs.	. last birthday)			If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	Birthpl Coun	ace (State of	or Foreign	
			217-44-7303 Usual Residence of Decedent	1 X -1M 2C1F		61 Yrs.		= 1			June 27,	1943 New York				
	yland IOW		10a. State 10b. County	,	10c. C	ity, Town or Lo	ocation							10	0d. Inside C	ity Limits
	the Marylar 28e-f show	ctor	Maryland Mon	tgomery		Silver	Spring								1 🗆 Yes	2 🔀 No
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<u> </u>	hould d Mer marke matic	٩	Cosimo D'Aprile 19a. Informant's Name/Relations	ship (Type Print)	·····	19b Maili	na Address	(Street a		na Me	ssina <i>l Route Numbe</i> .	r City o	Town Stat	e Zin	Code)	
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Je,	itam itam		20a. Method of Disposition	.,		Place of Dispo	sition (Nan	ne of	1		ate		cation - City	or To	wn, State	
Ë	Page ment cant: If		¹X☐ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5		Par	rklawn M			2	2005			zille,	Mary	land	
Baltimore,	permit. Depart Import eny inj		21. Signature of Funeral Service	Licensee By)	F 5	2. Name an rancis 00 Uni	J. Co versi	s of Facili Ollins ty biv	Funer a, w.	ral Home Silver	Inc. Sprir	ng, MD	2090)1	
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Record	The law requir ate has been s page 2 should	Completed								<u>.</u>	24a. Was a autop: perfor	sy	24b. Were prior death	to con	osy findings apletion of c	available ause of
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Division	ding h. After fune	Certification:	2 ☐ Accident invest	5 Pending (Month, Day Year) Injury Work? It investigation M 1 Yes 2 No							28d. Describe h					
Divi	7 5 5		4 Homicide determ	build	e of Injury - At t ding, etc. (Spec	ify)					28f. Location (S City or Tow	n, State)				iber,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 Medical one)				vestigation	, in my op	oinion, dea		ed at the time, d	late and	place, and o	due to	the cause(s	5)
	To To	2	29b. Signature and title of certific		}	10	290	License	number		2		e signed (Me			
	24+1		30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type,	Print)	10				rep	ruary 1	4,	2005	
_			Alan Schneide	,	313 Georg			6, Si	lver	Spring	, MD 2090)2				
	Sta Registr		31. Date filed (Month, Day, Year	2005	Registrar's Sign	S do	we									

State of Maryland / Department of Health and Mental Hygien 20 15 06895 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Angela Lucia deRosa ам February 11, 2005 /Medical 7:10 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Foundation Sandy Spring
If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Funeral Birthpface (State or Foreign Country) Days Hours 1 □ M 2 □ X F 091-12-3472 Yrs. Director 80 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Maritical Examinist must be notified at once. Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15115 Interlachen Drive 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Maritaf Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ KNo þ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Bartholomew Venza Francesca Barraca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa F. Nelson/ Daughter 12468 Wendell Holmes Road, Herndon, VA 20171 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Entombment Gate of Heaven Cemetery 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** 420 SEBIS disease or condition resulting in death) DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any has any leasing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery jo 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2X No Other: 1 Inpatient 2 ER/Cutpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3370C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMSPORT Ted Howe 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 5 2005 Registrar

		_	1 - For State Registrer	State of M	aryland / Depa <i>Cei</i>	artment of tificate of			Reg. No.	13 20	
	Physici		1. Decedent's Name (First, Middle, Last Joyce Ellen Davi					2. Date of De Month Februa :		∪ ე 2005	a. Time of beath 11:00AM
	/Medic Examin		4a. Facility Name (If not institution, give)		or Location of Deat	h		y of Death	
	Funeral Director		## Homewood at Will 5. Social Security Number 6. Se 220–16–3165		ge (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days			wasnir y 1923		County place (State or Foreign atry) Land
	Maryland I show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing	ton	10c. City, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes X No
	with the	Direc	10e. Street and Number			10f. Zip Code	505		10g. Citizen of		
9800	J within 72 hours after death with the Maryland jiene. Then "natural", or Items 23e or 28e-f show the Mcdical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No .	Was Decedent of f Yes, specify Culture 1 Yes 2 No		Specify Yes or Noto Rican, etc.)	United 14. Ra Bla Specia	ce - America ick, White, whit	can Indian,
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ore, Mar	permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: if item 27 is marked otha any injury or othar traumatic event, 000ce.		19a. Informant's Name/Relationship (T) James K. Davis (20a. Method of Disposition 1 ☒ Burial 2 □ Cremation 3 □ I	Son)	20b. Place of Dispo	South Ri	ver Landi	ng Edger Date	water Ma 20c. Location	rylar - City or To	nd 21037 own, State
Baltimore,	Department Page Department Important: If any Injury of once		'4 □ Donation 5 □ Other (Specify, 21. Signature of Editaral Service Licens		Rest nave	. Name and Addi	ess of Facility D	ouglas i	A. Fiery	Fune	Maryland eral Home and 21742
	Ilicate be executed Medical Examiner Thysician and Thysician a	dical Examiner	shock, or heart failure. List only of disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	s a consequence of): a consequence of): a consequence of):	Ni a	diou	sulor	Asca	Le	Interval Between Onset and Death
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ecords, P.	law requires that the same of	Š	Part II. Other pronificent conditions co	ntributing to death I	but not resulting in the ur	nderlying cause g	iven in Part I.	-	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
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	the the	Medical	(Check only 2 Medicel Exemone)	mer: On the basis of	of my knowledge, death of examination and/or inv lated.	estigation, in my	opinion, death occu	urred at the time,	date and place,	and due to	the cause(s)
	with To	4	29b. Signature and title of contifier	0/		D C	14050s	6	29d. Date signer	1515	2005
5H	- 🎖 Sta		30. Name and address of person who c	470	death (Item 23a) (Type,	The	Hagas	four	MO	21	742

			1 - For State Registrar	State of Man		artment of rtificate of		d Mental Hyg	iene	105 0000
	Physici ////		Decedent's Name (First, Middle, Las MICHELLE ENGLE	•				2. Date of Deat	h	3. Filme of Beath 2005 6:33 P M
	/Medi Examir		4a. Facility Name (If not institution, give 1730 OCEAN GATE)	street and number)		TRA		eath	4c. County	
	Funeral Director		5. Social Security Number 6. Security Number 19 19 19 19 19 19 19 19 19 19 19 19 19		n yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth Min. DEC 16 1	968	9. Birthplace (State or Foreign Country) MARYLAND
	death with the Maryland ms 23a or 28a-f show Livust to notified at	ctor	10a. State 10b. County MD TAL		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XXNo
	ith with th	Funeral Director	10e. Street and Number 1730 OCEAN GATEW.	AY, APT. D		10f. Zip Code	.673	11	og. Citizen of US	What Country?
9036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. It was a state of the trans 23a or 28a-f show than Ya is marked othar than "natural", or Itams 23a or 28a-f show other traumatic avant, it is My affect Exa. That I was be notified at	by	11. Marital Status 1 □ Never Married 2▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛱 No	oan, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Rad Blad Specify	e - American Indian, ck, White, etc. v: WHITE
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Maryland	ould be filed I Mental Hygi Narked othar Natic avant, II	To Be (17. Father's Name (First, Middle, Last) JOSEPH EDWARD EN	GLE				Name (First, Middle, A DA MAE JOHN		ne)
e, Mar	l and 2 sho lealth and im 27 is mu her trauma		19a. Informant's Name/Relationship (7) LINDA M. ENGLE/M	OTHER	4282	POPLAR N		PRESTON,	MD 216.	55
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau ODGS.		20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	JR. ORDE	natory or other pla ER CEMETE	ERY 2-			City or Town, State N, MARYLAND
Ba	perm Depa Impo any ii		21. Signature of Funeral Service Licens M. L. Dewve 23a. Part1. Enter the disease, or comp	m C.F.	s.P. I	200 S. HA	HELFENB RRISON	ST EASTON,	MD 21	
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. GUNSHOT	WOUNT		KEAD	nac of respiratory arre	st,	Approximate Interval Between Onset and Death
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P.O. Box 68	The law requires that the death certifica tte has been signed by the attending pt tage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 IRUnknown	23c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Dat	e of delivery nth Day Year
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)	Mith To	<	29b. Signature and title of certifier			29c. Licens			_	(Month, Day, Year)
				310,00			enn Str	eet Balti	more, 1	Maryland 21201
**	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7	32. Recorrar's S	The second of	Soull .				

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			1 - For State Registrar	State of Mary		artment of I rtificate of		R	eg. No. 200	06898
	Physici /Medic		1. Decedent's Name (First, Middle, Las	•				2. Date of Deat	Day Year	3. Time of Death 3. 8:30 a M
	Examir		4a. Facility Name (If not institution, give The Hermitage a		s Creek	4b. City, Town, o	or Location of Death		4c. County of Dea	ith
	Funeral Director		5. Social Security Number 6. Security Number 015-09-0619		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 12,	Year) 9. Bii	thplace (State or Foreign ountry) ssachusetts
	the Maryland 28a-f show notified at	ō	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-i	irect	MD Calver	T.		Solomoi 10f. Zip Code	ns	1	0g. Citizen of What C	21
	23e cust b	ai	13325 Dowell Road			2068	88		USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. itsm 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Marical Exemplications to the intiffied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:1 9 4		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☑ No	Hispanic Origin? (Specian, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi	
1215-0036	within 72 ho ene. then "netur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life.	DO NOT use retire	during most of working	g	16b. Kind of Business	
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Mai	and 2 sh salth and n 27 Is n		19a. Informant's Name/Relationship (T	npe, Print) aughter			and Number or Rural			Zip Code)
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	20b. Place of Dispo	sition (Name of matory or other pla	ce)		20736 20c. Location - City or Salem,	
Balti	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service Licens		ess of Facility Ineral Home	, P.A.,				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
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99 xo	eath certifica attending ph for use as t	/Med	IF FEMALE:	23c. If yes, outcome of p	raggaggy					
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	sign sign d be	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause giv	ven in Part I,		acco use contribute to s 2 □ No 3 □ Pr	,
Vital Records,		Completed						24a. Was an autopsy perform	prior to	itopsy findings available completion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Januari S. L.			26. Place of Death	Check only one)	Assisted
o	Phys this ral dii	n: To	27. Manner of Death	dospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	t 3 DOA Oth	Nursing Hom		nce 6 XOther (Spe w injury occurred	city) Living
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Division	- = c	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	ipecify)		ll t	City or Town,		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	n occurred at the tirvestigation, in my o	me, date and place, ar ppinion, death occurred	nd due to the car d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	Z	29b. Signature and title of certifier	M		29c. Licens	6314	29	d. Date signed (Monti	h, Day, Year)
	8		30. Name and address of person who call Pomilla, M.D.	110 Hog	nital Dr	C+0 21	0, Prince	Freder:	ar MD 20	670
	Sta Registr		31. Date filed (Month, Day Year)	32. Registra 3	Signature	An W	o, rince	TEGELI	CR, MU 20	678
					ANDER JO	MINEL				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** FEBRUARY 11, 2005 12:40 PM HARRY FRAZEE DARR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4229 KINGS ROAD ANNE ARUNDEL EDGEWATER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | SEPT. 11, 1920 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 14 □ M 2 □ F 7. Age (In vrs. last birthday) **Funeral** WASHINGTON D.C. 218 09 4100 84 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Evertines must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL EDGEWATER 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 4229 KINGS ROAD 21037 or itams 23a UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If item 27 is marked other than "natural; or itams 23a any injury or other traumatic event, the Wedical Exempler inverse once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? \□Yes 2 □No INYes, Give Year or Dates: 1942-46 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ BUSINESS COORDINATOR APPLIED PHYSICS LAB 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRY T.DARR PEARLE FRAZEE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 KING ST. GARY E. ROBERTS (NEPHEW) KEYSVILLE, VA. 23940-3551 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State KALAS CREMATORY 02-12-05 EDGEWATER, MD. ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neum and a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examine signed by the attending physician and the detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part (I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Lewian 1 ☐ Yes 2 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 □ Yes 2 □ Yo 26. Place of Ceath (Check only one) Be Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 28d. Tescribe how injury occurred 27 Manner of Death 28b Time of . After i Certification: Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrat's Signature 31. Date filed /Mo State Registrar

			State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygie	_	5. 5. 0.5.900
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day_ Ye	3. Time of Death
	/Medic		Josephine Dubicki		February		
	Examir	er	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		4c. County of D	
	Funeral Director		5. Social Security Number 144-28-3042 6. Sex 1 M 2 K 7. Age (In yrs. last birthday, 93 Yrs.	-	8. Date of Birth (Month, Day, Y May 3, 1		Birthplace (State or Foreign Country)
	within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28a-1 show than "motival Exemicer must be motified at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10c. City, Town or L Tracy's U 10e. Street and Number 6473 Old Solomons Island Road). Citizen of Wha	10d. Inside City Limits 1 Yes 2 No
0036	hours after de cural', or Items al Exeminer n	ed by Fune	1 Never Married 2 Married 1 Yes, Give 3 Nover Married 4 Divorced Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 Mo Specify:	Rican, etc.)	Specify: V	American Indian, White, etc.
21215-0036	d within 72 giene. er than "nat tre Medici	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hoste	adent's Usual Occupation e kind of work done during most of worki DO NOT use retired) PSS	ing	inance (·
Maryland	iould be file I Mental Hy harked othe	To Be (17. Father's Name (First, Middle, Last) Unknown Szurko	Unknown	e (First, Middle, Ma		
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, it a Modical Examiner must be notified at QDGs.		Walter Dubicki (Son) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MOO542	Old Solomons Isl. osition (Name of ematory or other place) Heaven Cem. 2 15105 2. Name and Address of Facility Rate P.O. Box 100, Owing	Rd., Trac	cy's Lar c. Location - City st Hanov ral Home	nding MD20779 yer, NJ e, P.A.
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P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of Month	delivery Day Year
	w requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death but not resulting in the cooperation in the cooperation.	anderlying cause given in Part I.		_	e to the cause of death? Probably 4 Junknown
al Records,	: The law requ cate has been , page 2 shoul	Completed	Pulmonay Hypertensia	-elt Lung	24a. Was an autopsy performed	do prior deat	
Division of Vital	utending Physician: The death. ctor: After this certificate hay the funeral director, page	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 impatient 2 ER/Outpatie 27. Mann: 1 Death		me 5 Residence		Specify)
Divis	tai or Attendrs after death al Director: , ed in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determin = 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location <i>(Str</i> ee <i>City</i> or Town, S	et and Number of State)	r Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Certifying Physician: To the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and	due to the cause(s)
	CO PO	-	29b. Signature and title of certifier	29c. License number D0 605 8 7 9 7		Date signed (M	
			30 Name and address of person who completed cause of death (Item 23a) (Type,	Print)	7	110/05	
	10		H: Young MD Anne Drudel 1	rédical carber, A	mapol	is Mo	2401
	Sta Registr	1.0	30. Name and address of percent who completed cause of death (Item 23a) (Type, U. Young M. Anne Arabel 31. Date filed (Month, Day, Year) 32. Registry's Signature FEB 1 4 2005 Message M.	Sperte			

			For	Please			k Indelible In Department of	f Health and I		_	le.
			1 - State Registrar				Certificate of	of Death		Reg. No U	15 0690
	Physic	ian		me (First, Middle, La. F. Dashie	•				2. Date of Dea Month	Day	3. Time of Death
	/Medi				e street and number)		4b. City. Town	n, or Location of Deati	+ZBRUM	4c. County of	
	Examir	ier	Peninsu	la legina	1 Medica	1600	50	1:=hurd		Wico	Oico
	Funeral		5. Social Security			e (In yrs. last bi	rthday) If Under 1 Ye Months Da		8. Date of Birti (Month, Day	h Year)	Birthplace (State or Foreig Country)
	Director		218-48-7	106	□M 2) ②F	54	Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Feb 16,	1950	MD
	fand ow		Usual Residence 10a. State	10b. County		10c. City, Tov	m or Location				10d. Inside City Limits
	Marylan I-f ehow	ģ	MD	Wicomio	co	Salis	bury				1 to Yes 2 □ No
	th the	Director	10e. Street and N	lumber		.1	10f. Zip Cod	е		10g. Citizen of Wh	nat Country?
	ath wi	rai	214 E. L	incoln Ave				1804		U.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at	by Funeral		rried 2[x]Married 4 □Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	13.	- American Indian, White, etc. Black
8	2 hou	ed		15. Decedent's Ed	ducation	16a	. Decedent's Usual Oc	cupation		16b. Kind of Busi	iness/Industry
21215-0036	hin 72	Completed	(Spi	ecify only highest gra	college (1-4or	5+)	(Give kind of work do life. DO NOT use re	ne during most of wor tired)	rking		
	filed with Hygiene. other than	E C		th	0011090 (1 401	.,	House	keeper		Medica	l Facility
nd	ital Hydrau doth	Be	17. Father's Name	e (First, Middle, Last,)			18. Mother's Nar	me (First, Middle,	Maiden Sumame)	t
Maryland	2 should be and Mental Is marked o	P P		rgan, Sr. Name/Relationship (Tuna Print)	101	Mailing Address (Chr		th Shimp		Tr. Codel
N N	id 2 sl ith an 27 Is r traur		1		s, husband		o. Mailing Address (Stra				
ē,	s 1 and 2 f Health item 27		20a. Method of D		i iusbana	20b. Place of	14 E. Linco of Disposition (Name of ary, crematory or other)		Date	20c, Location - C	
Baltimore,	0 0 = =			2 □ Cremation 3 □ n 5 □ Other (<i>Specif</i>]Removal from State y)	1	Acres Mem	1 1	2/05	Salisbu	rv. MD
alti	permit. Page Department o Important: If any injury or once.		21. Signature of I	Funeral Survice Liver	nsee		22. Name and Ad	dress of Facility			11112
<u> </u>	88 8 8		1	200			1618 West	Watson Fu	neral Ho lisbury	me -MD 2180:	1
	Physician /Medical Examiner		23a. Parti. Enter shock, or he Immediate Cause disease or condit resulting in death	e (Final tion	a. My w	a consequence	Someh	dying, such as cardiac	c or respiratory år	rest,	Approximate Interval Between Onset and Death
1760,	ite be executed ysician and ne burial-transit	icai Examiner	Sequentially list of any, leading to cause. Enter Uncause (Disease of that initiated ever resulting in death	nts	С.	a consequence		Tun			7200,
P.O. Box 687	The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the is	Physician/Medic	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	12 months? 2 III No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	n 3 ⊟Ectopic pregna 5 □ Other (specify,			23d. Date of Month	,
مز	res that the igned by be detact	by Pr	Part II. Other sign	nificant conditions	contributing to death b	out not resulting	in the underlying cause	given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
rds	quires en sign uld be	ed b	12,	Brgan	Jurayen				1 🗆 Y	es 2□No 3	☐ Probably 4 ☐Unknown
of Vital Records,	The law requir cate has been si page 2 should	Completed	12	Dith	Mellik				24a. Was a autop: perfor	med? prid	ere autopsy findings available to completion of cause of ath?
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case ref	erred to medical	112-1				ath (Check only or		
<u></u>	Q S	၉		No	Hospital: 1 Inpatio		utpatient 36 DOA			ence 6 Other	· · · · · · · · · · · · · · · · · · ·
Division	tending Phi death. tor: After thi the funeral	Certification:	27. Manner of De 1 Natural 2 Accident 3 Suicide	5 Pending			M 1	njury at Nork? I □ Yes 2 □ No		ow injury occurred	
<u>></u>	s after all Directed in Directed in by	Sertif	4 Homicide	determined	286. Place of in	c. (Specify)	arm, street, factory, offi	Ce	City or Tow	n, State)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai (29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exar	nysician: To the best miner: On the basis o and manner st	it examination ar	e, death occurred at the nd/or investigation, in m	e time, date and place by opinion, death occu	, and due to the corred at the time, co	ause(s) and mann late and place, and	er as stated. d due to the cause(s)
	To t Withi To t	Σ	29b. Signature ar	d title of certifier				ense number	2	29d. Date signed (Month, Day, Year)
	0 . 1		•	K)				21000		213	10%
7	Salle		Tar	WIND CH	completed cause of	MILK	coas R 6 V	s 51	M1.3. R4	m	21304
1	Sta	ate	31. Date filed (Mo		2005 32. Registr	ar's Signature	brack ;				

EYLER

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

Yeer

12, 2005

U.S.A.

Specify:

23d. Date of delivery

1 Yes

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 🗷 No

Year

Month

Race - American Indian, Black, White, etc.

White

4c. County of Death

2:00P

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

9. Birthplace (State or Foreign

Month FEBRUARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar = For State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Fecility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

MAY

VIRGINIA

egistrar's Signature

			For State Registrar		State o	of Mary	land	d / Depa	artmen rtificat			and M	lental i		ne No2	05	06	903
	Physicia	213	1. Decedent's Name (First, Mid-	fle, Last)									2. Date o Month	f Death	Day	Year	3. Time	
	/Medic	al	w.na	54	192	40%			11 02	T		(D	_ 2		\$	2005		22 CM
	Examin	er	4a. Facility Name (If not instituti			m <i>oer)</i>				lown, or	Location of	or Death				nty of Death		
	Funeral		5. Social Security Number	6. Sex	7.7	7. Age (In	yrs. l	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date o	Birth	1100	9. Birth	nplace (State	or Foreign
	Director		065-26-8167	10	M 2⊠F		10	1 Yrs.	Months	Days	Hours	Min.	8. Date o (Month April	21,	1903	Poli	and	
	pug *		Usual Residence of Decedent 10a. State 10b. Coun	······································		10	c. City	r, Town or Lo	ocation								10d. Inside	City Limits
	Aaryla f sho	ō					,	Rockv										s 2 No
	28e-	Director	Maryland Mont	gomer	- <u>y</u>			KOCKV	10f. Zip	Code				10g	. Citizen o	of What Cou	untry?	
	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-f show ha Madical Examinan must ke mulifical st	ai Di	6121 Montro	se Ro	oad					2	0852			Uni	ted S	States	s of A	merica
	ems ems	Funerai	11. Marital Status	1:	2. Was Dec		r in U.S	S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes o Rican, etc.	r No-		ace - Amei lack, White	rican Indian, e. etc.	
36	or its	by Fu	1 Never Married 2 Ma		1 ☐ Yes If Yes, Gi	2 X No we			1 🗆 Yes		Specify:			,	Spec	T 71	hite	
21215-0036	hour tural	ed b	3√ Widowed 4 □ Divorce		Year or D	Jates:	-	16a. Dece	dent's Usua	al Occupa	ation			16	b. Kind of	Business/I	ndustry	
715	nin 72 in "ne Medis	piet	(Specify only high Elementary/Secondary (0-12)	est grade	completed) College (_	(Give	kind of wo DO NOT u	rk done r	turina mos	t of work	ing				,	
212	e filed within al Hygiene. f other than 'vent, the Me	Completed	12		- Comege (1-401-017		Но	memak	er					Owr	n Home	e	
pu	be filed ta! Hygie d other event.	Be (17. Father's Name (First, Middle										First, Mi					
yla	should be and Mental I warked o	ဥ	Max Buchwei									arah				nable		
Maryland			19a. Informant's Name/Relation Marlene Ross			r				,			al Route Ni race		,		a, MD	20814
	is 1 and 2 of Health item 27 l		20a. Method of Disposition			2	20b. P1	lace of Dispo					Date	-			Town, State	
ē	0 - 4		1 Burial 2 Cremation 4 Donation 5 DOther		emoval from	State		_{emetery, crei} h Davi			Ł.	2/11	/05	E1	mont	Lone	g Isla	nd, NY
Baltimore,	e in it		21. Signature of Funeral Service		^	,	, , ,											
m	permil Depar Impor any ir		Sonald (. 1	tota	Tune	w	2	1178	Rock	Will	e Pi	ke, R	ockv	ille	, MD	20852	
,092	Physician /Medical Examiner pnulai-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if div, leading to intrinsitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.b.c.	Due to	(or as a co	naequ	uence of):	trac									
P.O. Box 687	death certificate e attending phy: id for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23		birth 2 nant at time	Fetal	death 3	⊒Ectopic pi ∃ Other (sp						A	Date of delivery	Day	Year
	es tha igned be de	by	Part II. Other significant condi		tributing to d	death but no	ot resu	ulting in the u	inderlying o	ause give	en in Part I						the cause of	
ord	v requir been si should	eted	17 Cayouza		,												obably 4	
Records,	e lav has je 2	Completed	14 boght s.	<u>}</u>									8	Mas an iutopsy performe es ™	d?	 Were auterior to condeath? 1 \(\sum \) Yes 	topsy finding completion of 2 \(\sum \) No	s available cause of
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to media examiner?	_							26. Place	of Deat	h (Check o					
of	ing Phys After this funeral dii	ပ္	1 ☐ Yes 2☐ No 27. Manner of Death 1☐ Natural 5 ☐ Pend		28a. Date			ER/Outpatier 28b. Time o Injury	_	28c. Injun Worl	43€€INU		me 5 🗆 F 28d. Descr				ify)	
Division	I or Attendia after death. Director: A d in by the fu	Certification;	3 Suicide 6 □ Coul	d not be mined	28e. Place build	e of Injury - ling, etc. (S	At ho	ome, farm, st	reet, factor	y, office				on (Stree Town, S		mber or Ru	ral Route Nu	imber,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certify 2 Medic	ing Physi al Examin	er: On the b	e best of m basis of exa	aminat	wledge, deat tion and/or in	h occurred ivestigation	at the tin	ne, date an pinion, dea	id place, ith occur	and due to red at the ti	the caus	se(s) and r	manner as e, and due	stated. to the cause	(s)
	To the within To the	Me	29b. Signature and title of certi	ier						c. License		`		29d	Date sign	ned (Month	n, Day, Year)	
)	7/		-	1	Dog	F 1413			7	2002	188	-1		6	18/2	05		
			30. Name and address of person	in who cor	mpleted cau	ise of death	ı (İtem	1 23а) (Туре,							2		K, N	Ø,
			24 Date filed (Afanth Day V	(e)	- A	Danietrar's	Signa	ture #	18	101	. 5	8F 6	2500	23		20	523	
	Sta Registi		31. Date filed (Month, Day, Yea	2005	bu	negistrar's	signa	ture Con	de									

			1 - For State Registrar	State of M	/larylar		artment rtificate			ınd Me	•	giene Reg. No	12 13	0.5	0 - 0	
	<u>.</u>		Decedent's Name (First, Middle, Las	t)						2	. Date of Dea	ath	i. U	UD	3. Time of Deal	thU
	Physici /Medi		Sophie F	uchs							Month Februa	ry 9	y, 200	eer 05	10:30P	М
	Examir		4e. Fecility Name (If not institution, give	street and numbe	r)		4b. City, 7	Town, or	Location of				. County of		201501	
			Hebrew Home of G					kvil					. S. A			
<i>*</i>	Funeral Director		5. Social Security Number 6. Se 055-18-3669 Usual Residence of Decedent	ox 7. A	1ge (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	Date of Birti (Month, Day July 2	r, Yeer)	1918	Birthpl Count Po1	ace (State or For ry) and	eign
	/land		10a, State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Lin	nits
	the Man 28a-f eh	ector	Maryland Montgom	ery	Roo	ckville	10f. Zip	Code				10- Cit	izen of Wha		1 ☐ Yes 2 ☐	No
	3e or		6121 Montrose Ro	o d			101. Z.p	208) E 2			•			ryr	
	death ms 2	Jera	11. Marital Status	12. Was Deceder	t Ever in U	.S. 13. V	Vas Decede			in? (Specif	y Yes or No- can, etc.)		J. S. 14. Race -		n Indian.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injurgor other traumatic event, the Medical Evantinar must be recitived at once.	by Fur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No		fYes, speci I□Yes 2			Puerto Rio	ćan, etc.)			White, e		
2-0	72 ho	ted	15. Decedent's Edi (Specify only highest grad	ucation		16a. Deced	lent's Usual	Occupa	tion	-4 -4:		16b. Ki	ind of Busin	ess/Ind	ustry	
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and	be fi	Be	17. Father's Name (First, Middle, Last)								irst, Middle,		Sumame)			
ž	nould d Mer narke	70	Henry Fuchs 19a. Informant's Name/Relationship (T	D. (a)							lerbau					
Ma	d 2 s th an traur traur		Henry Fuchs - Ne								oute Number				Code) k 11001	
ē,	1 an Heal tem 2		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name	e of	-	Date		_	cation - Cit			
OL.	OF F.		1 □ Burial 2 □ Cremation 3 □ 1 □ Cremation 3 □ 2 □ Cremation 3 □ 2 □ Cremation 3 □ 2 □ Cremation 3 □ 2 □ Cremation 3 □ 2 □ 2 □ 2 □ 2 □ 2 □ 2 □ 2 □ 2 □ 2 □	Removal from State	e c	emetery, crem	atory or oth	her place								
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m	Den fine per per per per per per per per per pe		Donald ()	State	· mar	Da 11	nzans 70 Ro	ky-G	oldbe	erg Me	emoria Rockv	L Ch	apels	, I	nc. nd 2085	2
	Physician /Medical Examiner	Examiner	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		s a consequ	GQA uence of):	_			-					nterval Between Onset and Death	
68760,	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	dical	that initiated events resulting in death) Last	Due to (or a.	s a consequ	uence of):										
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rds, P	quires that on signed build be deta	ρλ	Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the un	derlying cau	use given	in Part I.		23e. Did tob	~	<i>f</i> .		cause of death?	wn
000	aw s b	plet									24a. Was a		24b. Were	autops	y findings availal	ble
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	ystcien: is certific director.	To Be	examiner?	lospital:	ent 2 🗆	ER/Outpatient	3□ DOA	Other	. /		heck only on 5 ☐ Reside		- Co			
Division of	ding Ph h. After th funeral		27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury	28b. Time of Injury		c. Injury a Work?	ıt	28d.	Describe ho			ор в спу)		
Divis	i ii e	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, e	jury · At ho tc. (Specify	me, farm, stree	et, factory, o	office	White E	28f.	Location (Sti City or Town	reet and , State)	i Number o	r Rural f	Route Number,	
	To the Hospitel (within 24 hours at To the Funeral Dicompletely filled i	edical	29a. Certifier (Check only one) 1A Certifying Physical Exami	sician: To the best ner: On the basis of and manner s	or examinat	wledge, death ion and/or inve	occurred at estigation, in	the time	, date and p nion, death	place, and occurred a	due to the ca	use(s) a	and manne place, and	r as stat due to ti	ed. ne cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	206			29c. I	License r	number	211	29	d. Date	signed (M	onth, De	y, Year)	
	8		MIL CES	JM- D	_		لأ	1	808	1	F	EB	RUA	27 /	0,200	5
	o .		30. Name and address of person who co	empleted cause of	death (Item	23a) (Type, P	rint) UTR	D.E	RO	, 2	OCKI	l ica	E,l	(1)	ed. ne cause(s) y, Year) C, 200 20852	
9	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 4 20		rar's Signat	ure do	ules			/			(

John Fysck 05-1053 AKG

.05.	3		For AMEND#10f+20bp	State of M	aryland /	Depa	rtment	of H	ealth a	and N	lental Hy	giene	0.0	press.	
			Registra/HVLIVL#260211	E, 2/14/05, HM,	MbCo	Cer	tificate	of L	Death			teg. No	UU	5	06905
	Physicia	ın	Decedent's Name (First, Middle				337.0 GT				2. Date of Dea Month	Day	Ye		3. Time of Death
	/Medic		JOHN 4a. Facility Name (If not institution	CALVIN	· · · · · · · · · · · · · · · · · · ·	<u> </u>	YOCK 4b. City.	Town, or	Location of	of Death	Februa:		2005 county of D		1:26 P M
	Examin	er	Johns Hopkins				•	timo							
	Funeral		5. Social Security Number		ge (In yrs. last bi		If Under Months	1 Year Days	If Under	Min.	8. Date of Birt (Month, Day	h /, Year)	9.	Birthpla Count	ace (State or Foreign
	Director		579. 34. 0297	1 ⊠ M 2□F	75	Yrs.					March 1	6,19	29 Pe	nns	ÿlvania
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Lo	cation							10	d. Inside City Limits
	Mary I-f sh	tor	Maryland Montgo	omerv	Sil-	ver	Sprin	18							1 ☐ Yes 2½ No
	or 28g	Directo	10e. Street and Number					505				10g. Citize	en of What	Count	ry?
	ath wi	ral	14804 Maydale Co				- 208	350				U.S			
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent Armed Forces ied 1 ☐ Yes 2 ☑	?	13. V	Vas Deced I Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - A Black, W		
336	be filed within 72 hours after death with the Maryland hal Hygiene. od other then "natural", or Items 23a or 28a-f show event, the Madical Examiner must be notified at		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	140	1	∏Yes 2	2₩ No	Specify:			S	specify:	Wh	ite
21215-0036	72 ho	Completed by	15. Deceden (Specify only highes		168	a. Deced	lent's Usua	l Occupa	ition	t of work	ina	16b. Kind	d of Busine		
2	c * 39	nple	Elementary/Secondary (0-12)	College (1-4or			kind of wor OO NOT us				9				
	filed withi Hygiene. other then ent, I've M		17. Father's Name (First, Middle,	Last)	G	rapr	nic De	esig		er's Nam	e (First, Middle,		verti	sın	g
ano	ould be t Mental I arked o	To Be	Charles E. Fyocl								Miller				
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, II'e M	F	19a. Informant's Name/Relations		19	b. Mailin	g Address	(Street a			al Route Numbe	r, City or	Town, Stat	e, Zip (Code)
	1 and 2 Health a tem 27 is		Cheryl L. Capon	iti/Daughter						e Ter	rrace, ()1ney	, Mar	y1a	nd 20832
ore	of He of He If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of cemete	of Dispo: ery, cren	sition (Nam natory or ot	ne of ther place	θ)		Date 4		ation - City		
Baltimore,	thent of I than I file itant: If its itant or o		* 4 □ Donation 5 □ Other (S	pecify)	Gate										g, MD
Bai	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funeral Service	Licensee											Home, Inc.
			23a. Part 1. Enter the dease, or	complications that cause	d the death. Do								r spr		, MD 20904 Approximate Interval Between
	Physician		shock, or hear failure. List Immediate Cause (Final	. 1		0.	tha conta	in sob	i Cross	1:nucic	cular Di	101.10			Onset and Death
	/Medical		disease or condition resulting in death)		or Ensi Ve a consequence		TOCIUSCI	egoni	<u>c</u> unc	IIV VALS	ada or	wu _s c		-	
	Examiner		Sequentially list conditions.	b											
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	ol):									
•	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence	e ol):									
8760,	ate be executed thysician and the burial-transit			d											
9	The law requires that the death certificate be executed te has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	dedical	IC CCMALC.	1											
Вох	death certifical attending phy for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pre					23	d. Date of Month		y Day Year
0.	the all	/slcl	1 Yes 2 No	4□Pregnant a 9□ Unknown	it time of death	5 🗆	Other (sp	ecify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
<u>α</u>	res that the digned by the be detached		Part II. Other significant condition	ons contributing to death I	but not resulting	in the ur	nderlying ca	ause give	an in Part I	,	23e. Did to	bacco use	e contribut	e to the	cause of death?
Records,	quires n sign ald be	ed by									1 🗆 Y	es 20	No 3□] Proba	bly 4 🗍 Unknown
000	aw requir Is been si 2 should	Completed									24a. Was		24b. Were	autop	sy findings available
R	The lav	mo										med?	death	h? Yes 2	2 No
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?							of Deat	h (Check only o	ne)			
of \	Phys this al dii	4	1 XYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inj	7.75			- 4	4 140	ursing Ho	ome 5 Resid			Specity)	
no	ding T. After fune	tion	1 Natural 5 Pendir 2 Accident investi	g (Month, Da	ay Year)	Time of Injury	М	Bc. Injury Work	val √? Yes 2□	No	20d. Describe i	low injury	occurred		
Division	Attending ir death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At home, I	larm, str	eet, factory				28f. Location (S		Number o	r Rural	Route Number,
Ö	s after of Dire	Certification;	4 - Homicide determ	building, e	tc. (Specify)						City or Tow	m, State)			
	lospit hour unere		29a. Certifier 1 Certifyir (Check only 2 X Medical	ig Physicien: To the best Examiner: On the basis	t of my knowledg	ge, death	occurred a	at the tim	ne, date an	nd place,	and due to the	cause(s) a	nd manne	r as sta	ited.
	To the Hospitel or Attent within 24 hours after dealt To the Funerel Director: completely filled in by the	Medical	one) 29b. Signature and title of certifie	and manner s					number				signed (M		
\	10 Tel	-	250. Signature and title of certifie	a thall man			290								
	20		30. Name and address of person	who completed cause of	death (Item 23a)) (Type	Print)		CME			repr	uary	ΙU,	2005
			Pamela B	Southall MI)		111	L Per	nn St	reet	Baltim	ore,	Mary	1an	d 21201
	Sta		31. Date filed (Month, Day, Year)	32. S gist	rar's Signature	1	reales)							
L	Registi	ar	FEB 1	4 2005 Dec	المر المال	51									

WAP	A L. FO)LK	1 - For Stete Registrer	State of Ma	ryland		artment <i>tificate</i>			and M		giene Reg. No.	P 10 11	15 04	: a a c
	- Pĥysici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of De	Day	2005 ^Y	3. Time	of Death
	/Medic Examin		TOWANA L. FOLK 4a. Facility Name (If not institution, give SOUTHERN MARYLAN	street and number) D HOSPITAL	,		4b. City, To	OTW	Location o	of Death	FEB.	4c.	County of I	161 Death GEORGE	
	Funeral Director		5. Social Security Number 6. St 238 04 3649 Usual Residence of Decedent	ox 7. Age □M XXXF	(In yrs. las	st birthday) Yrs.	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da MAR. 3	ıy, Year)		Birthplace (Stat Country) MARYLAN	
nore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be rotilled at ODG.	To Be Completed by Funeral Director	10a. State 10b. County MARYLAND PRINCE C 10e. Street and Number 4510 LORDS LANDING 11. Marital Status 1 Never Married 2 Married 3 Widowed XX Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) EARL LEE 19a. Informant's Name/Relationship (1-1) AUDREY WATSON / AU 20a. Method of Disposition XX Buriai 2 Cremation 3 D	RD. #304 12. Was Decedes? Armed Forces? 1 □ Yes XXN If Yes, Give Year or Dates: ucation de completed) College (1-4or 5-4 1 YR. Type, Print) NT Removal from State	UPPI ver in U.S. 0	16a. Dece (Give life. I SECUR.) 19b. Mailir 4505 ce of Disponetery, crem	RLBORO 10f. Zip C Nas Deceder f Yes, specify I Yes XI Ident's Usual kind of work of NOT use TTY GU, In the state of	2 (at of History Cubar Cubar Cubar done digretired) ARD / Street a	specify: tion turing most REC 18. Mothe SHIRL and Number NUE	EPTI or's Name EY J or or Rura	ONIST O (First, Middle OHNSON OHNSON I Route Numb ITLAND	UNITION 16b. Ki MAL(Maiden er, City o MD 20c. Lo	Black, N Specify: I nd of Busin COLM (Sumame)	XXY ATES American Indian, White, etc. BLACK ess/Industry GROW A.M.	
Baltimore	permit. Pag Department Important: any injury once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		RESS) MA	. Name and	Address	of Facility FUNE	y RAL	5/2005 HOME 01	F MAF	NTON RYLANI MD 2	O,INC.	
8760,	certificate be executed Wedical Medical and Medical and State as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aMutty	conseque	Do not ent once of):	er the mode	of dying						Approxin Interval E Onset ar	etween
P.O. Box 6	that the death ed by the atter detached for u	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 None None None None None None None None	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown ontributing to death but	2 ☐ Fetal da ime of dea	eath 3 th 5 th	Ectopic preg	ify)	n in Part I.		23e. Did t		23d. Date of Month	delivery Day	Year
al Records,	The law requi ate has been s page 2 should	Completed									24a. Was	osy rmed?	24b. Wer	e autopsy finding	nknown s available cause of
Division of Vital	or Attending Physiter death. Nector: After this in by the funeral dii	Certification: To Be	25. Was case referred to medical examiner? X Yes 2 No No No No	Diamed - 1	Year) Ty - At hom (Specify)	8b. Time of Injury	-HRS	Other	r: 4□Nul	rsing Hor 2 No	Check on the control of the control	dence 6 how injury Street and wn, State,	y occurred	r Rural Route Ni	imber, to
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier Check only 2 Medical Exemone) 29b. Signature and title of certifier	vsicien: To the best of inarcan from the basis and manner stat	f my knowle	edge, death	rectigation, in	тну эрі	e, date and	d place, a	and due to the	cause(=) date and	place, and	r as stated. Justo to the saust	
R	5	9	I hodel.	completed cause of de	ath (Item 2	?3a) (Type,	Print)	00	CME	reet	Baltin		FEB.	10, 200!	5
	Sta Registr	ar	31. Date filed (Month, Day, Year) FEB 1 6 200		r's Signatui	· f	e								

LI.	AM FREE	IMA	N 1 - State Registrar	State of Maryland		artment of F			iene	
	Physicia /Medid Examin	al	Decedent's Name (First, Middle, Last) WILLIAM KEITH 4a. Fecility Name (If not institution, give s ATLANTIC GENERAL H	treet and number)		4b. City, Town, o	r Location of Death	2. Date of Deat Month FEB		Death
	Funeral Director		Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7 / 25 / 1	, Year)	9. Birthplace (State or Foreign Country) MD
	the Maryland 28a-f show notified at	Director	10a. State 10b. County DE Susse 10e. Street and Number		Town or Lo			1	0g. Citizen of Wh	10d. Inside City Limits 1 X Yes 2 □ No
036	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show valcal Examiner must be notilled at	by Funeral	16 Ruth St.	12. Was Decedent Ever in U.S Armed Forces? 1	ľ	199	175 lispanic Origin? (Spean, Mexican, Puerto F Specify:		US.	
2121	filed within 72 ho Hygiene. other than "natur ent, I're Modical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of workind)	g	16b. Kind of Busi	ing
aryiand	should be fill and Mental Hy is marked oth	To Be	17. Father's Name (First, Middle, Last) William H. Free 19a. Informant's Name/Relationship (Ty,		19b. Maili	ng Address (Street	18. Mother's Name Martha and Number or Flura.	Rayne		
saitimore, M	Pages 1 and 2 nent of Health int: if item 27 i		Patricia Freeman 20a. Method of Disposition 1 Burial 2 Kremation 3 R 4 Donation 5 Other (Specify)		ace of Dispo metery, crei	Ruth St. sition (Name of matory or other place nlopen Cr				ity or Town, State
Dair	permit. Pag Department important: i any injury o once.		21. Sign the Fune Aservice License 23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	intage	22	2. Name and Addre	ss of Facility he large states and states are larger to the same of the same o	clin, MI	e Funera D 21811	
8/60,	Contilicate be executed Medical Examines and formation a	dicai Examiner	snock, or near failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence.	ence of):		io v Dseur			Interval Between Onset and Death
O. Box 6	death e atter d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decenting the second second second second second second second second second second second second second second second second second sec	death 3[Ectopic pregnancy Other (specify)	1		23d. Date Monti	•
ecords, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death but not resul	lting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
Vital Reco	The law ate has b page 2 sl	e Completed	25. Was case referred to medical				OS Pilos d Doub		sy pri ned? de 2□No 1□	ere autopsy findings available or to completion of cause of atb! TYes 2 No
Division of VII	i or Attending Physician: after death. Director: After this certifica I in by the funeral director, I	Certification; To Be	examiner?		ER/Outpatier 28b. Time o Injury me, farm, str	f 28c. Injur Wor M 1 🗆	y at k? Yes 2 \(\text{No} \)	ne 5 Reside 8d. Describe ho	ence 6 Other ow injury occurred	
_	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical Ce	29a. Certifier (Check only one) 29b. Signature and title of certifier	sicien: To the best of my knowner: On the basis of examination and manner stated.	vledge, deat on and/or in	vestigation, in my o	pinion, death occurre	d at the time, d	ate and place, an 9d. Date signed (d due to the cause(s) (Month, Day, Year)
٤	T 3	ate	30. Name and address of person who co	mpleted cause of death (Item A	<u> </u>	Print) 111 Per	n Street	Baltimo		13, 2005 land 21201
17	316	ле	FFR 1520	105	KA	hards &				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FE/NGOLD **Physician** FREDA 2:00 A.M. FEB 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** EIKton

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Hospital Cecil Union 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Director 211-20-05-27 Austria MARCH 9, 1908 Usuel Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits and Mental Hygiene.
and Mental Hygiene.
Is marked other than "natural", or itams 23a or 28a-1 show
reumatic event, the Medical Examinar must be notified at 1 ¥Yes 2 □ No NEW Director NEWARK 10g. Citizen of What Country? Village Road 200 U.S.A. Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Funerai 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO_NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Sales person 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Manguli's Nonma Mangulis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, permit. Pages 1 and 2 Department of Health ai Important; If itam 27 is 45 West Village Rd, Newark, DE 19713

ce of Disposition (Name of metery, crematory or other place)

Shanon Cemeters 2/20/05 Springfield, PA Rose Norma or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sharon Cemeter ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility emorred any ir Wilm., DE 19809 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (aus (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK 1 day /Medical Due to (or as a consequence of): Examiner 1 DAY ACIDOSIS METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed ACUTE REPORT FAILURE LDAY Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ISCHEMIL GOLITIS 1 Day ACUTZ use as been signed by the attending should be detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SUPLAVENTRICULAR 1 ☐ Yes 2 🐼 No 3 ☐ Probably 4 ☐ Unknown TACHYCARDIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient Certification: To 2 ER/Outpatient 3 DOA To the Funeral Director: After this completely filled in by the funeral di 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 | Homicide 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058392 m. D FEBLVARY 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SAMOREA UNION HOSPITAL, IDE SOW STIEST, ECKTON, MD 21921 GAUTAM 31. Date filed (Month, Day, Year) 32 Registrar's Signature Staté 7 2005 Registrar

		1 - For State Registrar	Julie Of IV	-	Certificate		and Mental Hy	Reg. No.	005	06909
Physici	an	1. Decedent's Name (First, Middle,	, Last)				2. Date of De	eath Day	Year	3. Time of Death
/Medic /Medic Examir	cal	Catherine 4a. Facility Name (If not institution,	give street and number	G.	Fets 4b. City, To	ko wn, or Location o	Februa:	ry 12,		10:55a M
		Hillhaven Nursi		//	Adel	ohi	24 Hm 0 D : (5)	Pr	ince Ge	orge's
uneral rector		,	6. Sex 7. A	ge (In yrs. last birti	nday) If Under 1 Months I		Min. (Month, Da	ay, Year)		lace (State or Foreign try)
		Usual Residence of Decedent		90			May 16	, 1914	Penr	sylvania
show	_	10a. State 10b. County		10c. City, Town					1	0d. Inside City Limits 1 Yes 2 No
Sa-f	ecto		gomery	Silver	Spring			40 000		
Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	5	10e. Street and Number			10f. Zip C			10g. Citizen	of What Coun	itry?
	ıera	713 Downs Drive 11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was Deceder	0904 nt of Hispanic Orig	gin? (Specify Yes or No	D- 14. I	USA Race - Americ	an Indian,
e e	Ē	1 Never Married 2 Marrie	Armed Forces ad 1 Tyes 22 If Yes, Give			Cuban, Mexican No Specify:	, Puerto Rican, etc.)		Black, White,	etc.
Ea	d b	▼▼Widowed 4 Divorced	Year or Dates					Spe	ecify: Whi	te
edica	lete	15. Decedent' (Specify only highest		16a.	Decedent's Usual ((Give kind of work life. DO NOT use	done durina most	of working	16b. Kind o	of Business/Inc	dustry
Tree IV	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)	File C			Post	tal Uni	on
ent,	e C	17. Father's Name (First, Middle, L	ast)				r's Name (First, Middle			
lic ev	0 8	Paul Glubshinsk	v			Cati	herine Cal	llovini	•	
nma	-	19a. Informant's Name/Relationsh		19b.	Mailing Address (S		r or Rural Route Numb			Code)
er tr		Paula Lee / Dau	ghter				Rockville,			0853
O		20a. Method of Disposition 1 XX urial 2 ☐ Cremation	3 □Removal from State	cemetery	Disposition (Name r, crematory or other	ar place)	Date		on - City or To	
iny		'4 □Donation 5 □ Other (Sp	ecity	Gate o			y 2/15/05			
any in		21. Signature of Funeral Service	icensee				Hines Rina hire Ave Si			
		23a Part 1. Enter the disease, or o	complications that cause	ed the death. Do no					PLIE,	Approximate
ician dical dical hipe private transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to in recitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyperte	cive Hear s a consequence o	f): ()-	2				Onset and Death
as the buri	cal	IF FEMALE:	d							
detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopic preg 5 □ Other (spec				Date of delive Month	ry Day Year
be deta	by Pt	Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying cau	se given in Part I.	23e. Did t	obacco use c	ontribute to th	e cause of death?
۵.							1 🗆	Yes 2□No	3 ☐ Proba	ably 4 🛣 Unknown
P	Completed						24a. Was autor perfo	psy ormed?	b. Were autor prior to con death? 1 \(\sum \text{Yes}	osy findings available appletion of cause of
e nas been age 2 shouk	e C	25. Was case referred to medical				26. Place	of Death (Check only of			
page 2 should			Hospital: 1 Inpat	ient 2 ER/Out	patient 3 DOA	Other: 4 🔀 Nui	rsing Home 5 🗆 Resi	dence 6 🗆	Other (Specify)
director, page 2 shoule	0 0	examiner? 1 ☐ Yes 2 ऋ No		ury 28b. Ti	me of 28c	Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe			
e funeral director, page 2 shoule	To B	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig:	ation	ay ⁱ Year) In	М	1 103 2 1				
e funeral director, page 2 should	Certification: To B	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investig: 6 Could n determin	(Month, D ation ot be ned 28e. Place of li building, s	njury - At home, fari	m, street, factory, o	ffice	City or To	wn, State)		Route Number,
e funeral director, page 2 should	dical Certification: To B	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 No 5 Pending investig: 6 Could n determing 2 Medical E	ation of be 28e. Place of Ir	njury - At home, far toc. (Specify) t of my knowledge, of examination and	death occurred at	ffice the time, date and my opinion, deat	City or Ton d place, and due to the h occurred at the time,	wn, State) cause(s) and date and place	manner as sta	ated. the cause(s)
e funeral director, page 2 should	Certification: To B	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical E	(Month, Dation of the ned 28e. Place of Ir building, control of the building of the basis ixaminer: On the basis	njury - At home, far toc. (Specify) t of my knowledge, of examination and	death occurred at /or investigation, in	iffice the time, date and my opinion, deat	City or Ton d place, and due to the h occurred at the time,	wn, State) cause(s) and date and place	manner as sta	ated. the cause(s)
r: After this certificate has been le funeral director, page 2 shoule	dical Certification: To B	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signafure and title Centifier	Month, Dation of the ned 28e. Place of Ir building, a graysician: To the best examiner: On the basis and manner s	ay Year) In Injury - At home, fan tic. (Specify) t of my knowledge, of examination and tated.	death occurred at for investigation, in	ffice the time, date and my opinion, deat	City or Ton d place, and due to the h occurred at the time,	cause(s) and date and place 29d. Date sig	manner as sta	ated. the cause(s) Day, Year)
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	dical Certification: To B	1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 2 No 5 Pending investig: 6 Could n determing 2 Medical E	Month, Dation of the ned 28e. Place of Ir building, a physician: To the best xaminer: On the basis and manner support of the page 28 and manner support of the page 28 and manner support of the page 28 and manner support of the page 28 and manner support of the page 28 and page 28 a	ay Year) In Injury - At home, fan stc. (Specify) t of my knowledge, of examination and tated.	death occurred at /or investigation, in 29c. L	the time, date and my opinion, deat idease number 00053337	City or Tou	cause(s) and date and place 29d. Date sig	manner as stree, and due to gned (Month, I	ated. the cause(s) Day, Year) 2005

		•	For State Registrar	State of Ma		Depa		t of He	ealth and	•		e 200	5 06910
	Physici		Decedent's Name (First, Middle, Last)	S. Nor	man FEI	NGOI	LD	-		2. Date of Month	D	ay Year	3. Time of Death
3	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or I	Location of Dea			3, 2005 c. County of Dea	
			Manor Care Nursin					hesda				ontgome	
	Funeral Director		5. Social Security Number 6. Sex 12	7. Age [M 2□F	91	oirthday) Yrs.	If Under Months	1 Year Days	Hours Min	. (Month,			rthplace (State or Foreign ountry)
			Usual Residence of Decedent							Feb.	2, 19	14 Mas	sachusetts
	Marylan a-f show	tor	10a. State 10b. County Maryland Montgome	ery	10c. City, To		cation 7111e						10d. Inside City Limits 1 ☐ Yes 3☐ No
	th with the 23e or 28s	al Direc	10e. Street and Number 1801 E. Jefferson	Street #	442		10f. Zip	Code 208	552		_	itizen of What C	•
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	I2. Was Decedent II. Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes		panic Origin? (S , Mexican, Puer Specify:	Specify Yes or to Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
21215-0036	d within 72 ho piene. r than "natur The Medical	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			(Give life. l	lent's Usua kind of wor DO NOT us 7Cholo	rk done du se retired)	iring most of wo	rking	Ps	Kind of Business ycholog ivate P	у,
Maryland 2	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) William Feingold							a Sali			
Mar	th and the and		19a. Informant's Name/Relationship (Ty) Margaret Baritz,	•								or Town, State, ase, MD	Zip Code) 20815
ē,	Heal Item		20a. Method of Disposition		20b. Place cemel					Date 15/05	-	ocation - City o	
<u>i</u>	Page ment annt: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Judea				1	13/03	01	ney, MD	
Baltimore,	permit. Departimont Import any injury		21. Signature of Funeral Service License	-	\Rightarrow	Tо	Name and	oler	Hohmore	Funeral	II	2.0	00010
	Physician /Medical Examiner		23a. Part 1. Fri The disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Sepsis Due to (or as a	a consequence	e of):				c of respirator	y arrest,	, , ,	2 0012 proximate Interval Between Onset and Death
	sit ad	iner	Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence	e of):							
,092	certificates be executed ording physician and ise as the burial-transit	cal Examiner	that initiated events resulting in death) Last	Alzheim Due to (or as a	consequence	e of):							
P.O. Box 68	ath certifica attending pl tor use as t	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel deat		Ectopic pre				-	23d. Date of de Month	livery Day Year
	w requires that the de been signed by the should be detached	ed by P	Part II. Other significant conditions con	tributing to death bu	it not resulting	in the ur	nderlying ca	ause giver	n in Part I.				o the cause of death? robably 4 ⊠Unknown
al Records,		Completed								pe 1 ☐ Ye	itopsy informed? s 2 7 N	prior to death?	utopsy findings available completion of cause of
Vital	Physician: this certition	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	nt 2 ERVO	Outpatien	t 3 DO	Other	26. Place of De			6 ☐Other (Spe	acifu)
ion of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir		27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y 28b	Time of Injury		Bc. Injury a Work?	at	28d. Describ			wiyy
Division	tal or Atters as al Directored in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At home, . (Specify)	farm, str	eet, factory,	, office			n (Street a Town, Stat		ural Route Number,
	the Hospi in 24 hou he Funer pletely till	Medical	29a. Certifier (Check only one) 1 Certifying Physical Control one)	ician: To the best of er: On the basis of and manner sta	examination a	ge, death and/or inv	occurred a restigation,	at the time in my opi	e, date and place nion, death occu	e, and due to to urred at the tim	ne cause(s e, date an	s) and manner a d place, and du	s stated. e to the cause(s)
	2011	Σ	29b. Signature and title of certifier	Vohr	ON	1.1) 29c.	D 2	number 0274			ate signed (Mon. 13/05	th, Day, Year)
	,,		30. Name and address of person who co						1	00017			
	Sta	to.	Kirti Vohra, M.D. 31. Date filed (Month, Day, Year)					thes	da, MD	20817			
	Registi		FEB 1 5 201	05 March	r's Signature	1	and !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Director

Baltimore, Maryland 21215-0036

247-68-916

Physiciar /Medica Examine

Funeral

Division of Vital Records, P.O. Box 68760,

Fields, Kaven 439929

Department of the population o	
Physician /Medical Examiner	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
100	

KAREN	MAE	FIEL	DC		Month	i 2 P	8:30 AN
4a. Facility Name (If not institution, give		FIEL		or Location of De		4c. County of C	
ATLANTIC GENERAL			BER			WORCES	
5. Social Security Number 6. Se		(In yrs. last birthda	ay) If Under 1 Year	If Under 24 H		9.	Birthplace (State or Foreign
	□M 2 K)F ,	48 Yrs.	Months Days	Hours Mi	JAN. 19	Year)	Country) MARYLAND
Usual Residence of Decedent						,	
10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
MARYLAND WORCEST	'ER	OCEAN	CITY				1 X Yes 2 □ No
10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
202 32ND ST.,	APT. 209		2184	2		USA	
11. Marital Status	12. Was Decedent E	ver in U.S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or No-		American Indian, Vhite, etc.
1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	0	1 ☐ Yes 2 🕅 No		, , , , , , , ,	Specify:	_
3 Widowed 4 Divorced	Year or Dates:					орослу.	
15. Decedent's Edu (Specify only highest grad	ucation le <i>completed)</i>	16a. De	icedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of и	vorking	16b. Kind of Busine	ess/Industry
Elementary/Secondary (0-12)	College (1-4or 5-	+) in				OLDY HO	ME
12	-		HOMEMAKE		lana (Fina Asidala)	OWN HO	ME
17. Father's Name (First, Middle, Last)	HEDOEG	CD			lame (First, Middle, I	,	
ROBERT M.	HEDGES	SR.				cDEVITT	
19a. Informant's Name/Relationship (T)			ailing Address (Stree				
MARY HEDGES/MOTHE	R		GLOUCESTE	R ROAD,			
20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	cemetery, of	sposition (Name of crematory or other pla	ice)	Date	20c. Location - City	or Iown, State
*4 Donation 5 Other (Specify)) 	GARDEN (OF THE PIN	IES 2/:	17/05	BERLIN,	MARYLAND
21. Signature of Fune)al Service Licens	609		22. Name and Address				
- Karles W	Hart		HASTINGS E	UNERAL I	HOME, SELE	SYVILLE,	DE. 19975
23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o	lications that caused one cause of the chin	the death. Do not	enter the mode of dy	ng, such as card	iac or respiratory arri	est,	Approximate Interval Between
Immediate Cause (Final disease or condition	Delete		ruous a	1. 4.3			Onset and Death
resulting in death)	a. Due to (or as a	consequence of):		Charles 1 -			- Janys
Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).					
	c.						
resulting in death) Last		consequence of):					
	d						
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		205-1			23d. Oate of	delivery
in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	У		Month	Day Year
9 Unknown	9□ Unknown						
Part II. Other significant conditions co	intributing to death bu	t not resulting in the	e underlying cause gr	ven in Part I.	23e. Did tot	pacco use contribut	e to the cause of death?
					1 🗀 Y€	ss 2□No 3□	Probably 4 Honknown
					24a. Was a	n 24b. Were	autopsy findings available
					- autops perforr	ned2 deat	
25. Was case referred to medical				-00 Di15		20 No 10	Yes 2 No
examiner?	Hospital:	# 2 DED/O	1001 20 DC4 Ot	hac	leath (Check only on		3
27. Manner of Death	1 Inpatier		TIGHT SELECT	→ □ Indiality	Home 5 Reside	ence 6 Other (Sow injury occurred	specity)
1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) Injur	y Wo	rk?]Yes 2 □ No	222. 3330100 110	ooouiiou	
2 Accident investigation 3 Suicide 6 Could not be	28e Place of Init	ny . At home fac-			28f Location (Ct	reat and Number o	r Rural Route Number,
4 Homicide determined	building, etc	. (Specify)	street, factory, office		City or Town	n, State)	nutal noute NUMBEL,
20a Carting Constitution	relates. To the hear	6 m lman. 1- 3			M		
29a. Certifier 1 ☑ Certifying Phy (Check only 2 ☐ Medical Exami	rsician: To the best o iner: On the basis of and manner star	examination and/or	eath occurred at the tr r investigation, in my	me, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
29b. Signature and title of certifier	//		29c. Licen	se number	2	9d. Date signed (M	onth, Day, Year)
1 - le	1- ph	Ell'is	44	4182		2/13/	
30. Name and address of person who co	ompleted cause of As	ath (Item 23a) (Tur	pe. Print	100)		37.370	J
Robert Der	Kin 97	233 14/1	122 il		Re-le-	nel	

State Registrar

31. Date filed (Month, Day, Year) FEB 15 2005

RJ

31300			1 - For State Registrar		aryland / Der		Health and N	Mental Hygi	•	5 06012
F	hysici /Medic		1. Decedent's Name (First, Middle, La	Cynthia L	ee Fazenbaker			2. Date of Death Month February		3. Time of Death 75 12:12 P.M
	Examin		4a. Facility Name (If not institution, given Sacred Heart Hosp 5. Social Security Number 6.5	oital	ge (In yrs. last birthda)	Cumberl	or Location of Death and If Under 24 Hrs.	8 Date of Righ	4c. County of D	County
Di	uneral rector		216-50-0167 Usual Residence of Decedent	1□M 2ØF	56 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 20,		Birthplace (State or Foreign Country) Maryland
the Marylar	28a-f show	Director	10a. State Maryland 10b. County Al	legany	10c. City, Town or t		Lonaconing	10	0.000	10d. Inside City Limits 1 ☐ Yes 25 No
ath with	s 23a or	eral Dir	1 Roo	osevelt Way		10f. Zip Code	21539			USA
G Z1Z13-UU30 filled within 72 hours after death with the Maryland Hygiene.	"natural", or itams 23a or 28a-f show calcal Exertirer ust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No 13	R. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2,00 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
VIZIS-0036 within 72 hours affiene.	rthan "natul The Medical	Completed by	15. Decedent's E (Specify only highest gra- Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+) 16a. Dec (Giv life.	edent's Usual Occup re kind of work done DO NOT use retire	eation during most of work d) Racetrack	ing	6b. Kind of Busine	ss/industry
_ o _	otha vant,	To Be C	17. Father's Name (First, Middle, Last	Joseph Schul	tz		18. Mother's Nam	e (First, Middle, Mar Mar	aiden Sumame) y McPeters	
Mar and 2 sho alth and	n 27 ia m er traum		19a. Informant's Name/Relationship (Francis Greggor		19b. Mai	iling Address (Street	and Number or Rur 1 Roosevelt W			ı, Zip Code)
Saltimore,	important: if Itam 27 ia marked any injury or other traumatic e QDGB.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	(y)		position (Name of ematory or other place imberland Crem	ce) F		Oc. Location - City	or Town, State and, Maryland
Deparit	any in		21. Signature of Funeral Service Lice	ye'			enzie Funeral l			Approximate
I be executed SX	sician and edical miner	dical Examiner	23a Pan1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pulm Due to (or as b. Right Due to (or as	a consequence of): a consequence of): a consequence of):	hronibi ep Veik	+4 ron	rboses		Interval Between Onset and Death
O. BOX 68 the death certifica	signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of o	delivery Day Year
COLDS, P.O	been signed b should be deta	by	Part II. Other significant conditions of	contributing to death t	out not resulting in the	underlying cause giv	en in Part I.			to the cause of death? Probably 4 Munknown
I MeC	certificate has be rector, page 2 sho	Completed		7112.					prior t	
Phys	After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigation	Hospital: 1 Inpati		of 28c. Injun Wor	er: 4 Nursing Ho	me 5 Resident 28d. Describe how	ce 6 Other (Sp	vecify)
= 3.5	·= c	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of In	iury · At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (Stre City or Town,		Rural Aoute Number,
To the Hospital o	To tha Funal completely fil	ledical	one)	nysician: To the best miner: On the basis of and manner st	of my knowledge, dea if examination and/or in ated.	nvestigation, in my o	pinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
Tot	To I	M	CUT-N	uld	Al-	29c. License OCME	e number		Date signed (Mo ebruary	
le '			30. Name and address of person who	ALL 1	761	111	Penn Stre	et Balti	more, Ma	ryland 21201
\$ 3 34, 1	Sta Registr		31. Date filed (Month, Day, Year) MAR .0 .	32. Regis	r's Signature	Sporte				

		1 - State Registrar	epartment of Health and N Certificate of Death	Reg.	ne No 2005 06013
Physic		1. Decedent's Name (First, Middle, Last) Jacqueline L. (Ganey	2. Date of Death Month February	14, 2005 2:30 PM
/Medi Exami		4a. Facility Name (If not institution, give street and number) 5805 42nd Avenue #415	4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 1 □ M 2 🖫 73 Yrs	(ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, You January 7	9. Birthplace (State or Foreign
p		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location	quitary /	1932 Washing Coll DC
ith the Marylar or 28a-f show	ctor	Maryland Prince George's	Hyattsville		1½ Yes 2 □ No
with the	i Director	10e. Street and Number 5805 42nd Avenue #415	10f. Zip Code 20781	10g.	Citizen of What Country? USA
IOTE, MIRTYIARG ZIZIS-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natursi", or items 23a or 28a-1 show or other treumatic event, tre Medical Examinating Conflict at	by Funeral		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2♥ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
72 hours af	Completed	15. Decedent's Education (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	ting 161	b. Kind of Business/Industry
G Z I Z I	Comp	Elementary/Secondary (0-12) College (1-4or 5+) "" 12th	Clerk-Typist		Private
id be fill hental Hikad oth	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai herine Be	
Waryian 12 should be h and Mental 7 Is markad treumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Run 5 42nd Avenue #415		
ore, IN stand; of Health litem 27	H	20a. Method of Disposition 20b. Place of Di	AND DESCRIPTION OF THE PARTY OF		Location - City or Town, State
TIIT transformation transformation transformation		'4 Donation 5 Other (Specify) 21. Signature of Gneral Service Licensee	ncoln Cemetery 2/18, 22. Name and Address of FacilityReno		rentwood, MD
Demi Depa Impo		Auhan Paul	9013 Annapolis Roa	ad, Lanhar	n MD 20706
Physician		23a. B.f.1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one use on each line. Immediate Cause (Final disease or condition resulting in death)	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
cate be executed x and physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	MELLITUS		
that the death certificated by the attending phetached for use as It	hysician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
COTGS, F.C. w requires that the sbeen signed by the should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the $\mathbb{N} \in \mathbb{N} / \mathbb{A}$	e underlying cause given in Part I,	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The law The law ate has b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? Ne 1 Yes 2 No
OT VICAL Physician: The This certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	O#	h (Check only one)	e 6 ∏Other (Specify)
ding h. After fune	ertification; T	27. Manny of Death Natural 5 Pending (Month, Day Year) 2 Accident investigation	e of 28c. Injury at	28d. Describe how i	
UIVISION let or Attending s after death. al Director: Afte	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, did not be the control of the date of examination and/or and manner stated.	ath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the causered at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
(5)		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		
		REVA · S · GILL 6510 Ken(1) 31. Date filed (Month, Day, Year) 2. Registrar's Signature	worth Ave Re	iverdel	mo 20737
St Regist	ate trar	FEB 1 6 2005	od .		

			_ For	State of Maryland	d / Depa	artment of H	lealth and M	-	•	5 00011
			1 - Stete Registrar		Cei	tificate of	Death	R	eg. No.	0 00914
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) STEPHEN FRANK	K GENTILE				2. Date of Deal Month FEBRUAR	Day Yea	1.4
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death		4c. County of De	
			ANNE ARUNDEL MEDI	CAL CENTER			S, MARYL	AND	ANNE AR	UNDEL
	Funeral Director		223-74-8004	7. Age (In yrs. I 54	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 11/10/1	9. t 950 M	Birthplace (State or Foreign Country) ARYLAND
	p 3		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Lo	cation				10d. Inside City Limits
	f sho	ō		NII MI	T 1 077	2017				1 Yes 2√7No
	the the	Director	VA SHENANDO 10e. Street and Number	JAH MT.	JACK	10f. Zîp Code		1	0g. Citizen of What	Country?
	3a or		308 BRUSH LEAF LA	ANE		22842)		UNITED S	TATES
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,
0	after or ite		1 ∑Never Married 2 ☐ Married	1 ☐ Yes 2/DXNo If Yes, Give		1 □ Yes XXNo	Specify:	nican, etc.)	Black, W Specify: W	
3	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	51		. ,			
ה ה	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. do ther than "natural", or items 23a or 28a-f show avant, the Medical Examinar must be notified at event, the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work	ing	16b. Kind of Busine	ss/Industry
7	withir ene. then	μŽ	Elementary/Secondary (0-12)	College (1-4or 5+)		EMPLOYED	u)		PRINTIN	C
У 5	filed Hygi other	a	17. Father's Name (First, Middle, Last)		DDLL .	DILL DO LID	18. Mother's Nam	e (First, Middle, i		<u> </u>
U	id be lental kad c	To B	FRANK N. GENTILE				EUNICE	E. MILL	ER	
ary	s 1 and 2 should be f Health and Mental Item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type	ре, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number	, City or Town, State	a, Zip Code)
Ž	and 2		MATTHEW S. GENTILE	E - BROTHER	107 1	N. PATRIC	CK ST. ALE	EXANDRIA	, VA 223	14
e G	permit. Pages 1 and 2 Department of Health & Important: if Item 27 i any injury or other tra once.		20a. Method of Disposition 1 XXurial 2 □ Cremation 3 □ R		lace of Dispo	sition (Name of matory or other place	се)	Date	20c. Location - City	or Town, State
Ĕ	nit, Pag- lartment ortant: i injury o		'4 □ Donation 5 □ Other (Specify)	FA]	RFAX 1	MEMORIAL	PARK 2/18	3/05	FAIRFAX,	VIRGINIA
baltimo	permit. Depart Import any inj once.		21 Signature of Funeral Service License			2. Name and Addre			FUNERAL H	
_	70 E 2 9		Cooxes						XANDKIA V	7.0
	Physician /Medical Examiner	je.	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	-7	e (i) uence of):	ier di	-	or respiratory an	631,	Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause Thompson Cause (Disease or injury that initiated events	Alcahela	Lusa	•				
5	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
-	te be ysicia ne bur	cal		l						
20	entifica ing ph e as th	Med	IF FEMALE:							
O. Box	the death certificate be executed y the attending physician and tched for use as the buriat-transit	Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3[Ectopic pregnancy Other (specify)	у		23d. Date of Month	delivery Day Year
ř.	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
cords	law requires that as been signed b 2 should be deta	leted b						1 □ Y	es 2⊒No 3□	Probably 4 Unknown
eco	law rel as bee 2 sho	plet						24a. Was a	n 24b. Were	autopsy findings available to completion of cause of
r	ician: The lav certificate has ector, page 2	ompl						autops perfor	med? 📈 💮 death	es 2 No
VITai	ysician: is certifica director, I	Be C	25. Was case referred to medical examiner?				26. Place of Deat			
0 0	Attending Physician: r death, actor: Atter this certific by the funeral director,	2	1 ☐ Yes 2 ☐ No		ER/Outpatier		4 Nulsing He		ence 6 Other (S	pecify)
	ding P h. After t funera	0 ::	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	rk?	28d. Describe h	ow injury occurred	
DIVISION	ttend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injuny At he	amo form at		Yes 2 □ No	29f Location /C	troot and Number or	Pural Pauta Number
⋛	Diffe	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	reet, factory, office		City or Town	n, State)	Rural Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier A Certifying Phys	sician: To the best of my kno	wledge, deat	h occurred at the tir	me, date and place.	and due to the c	ause(s) and manner	as stated.
	n 24 h	Medical	(Check only one)	ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	opinion, death occur	red at the time, d	ate and place, and o	lue to the cause(s)
	To the Vithin 2 To the Complet	Z	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
_			Stiph (DS	585/0		02/13/	05,
V	(10)		30. Hame and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)				
1			31. Date filed (Month, Day, Year)	→ Registrar's Signa	ture					
	Sta Regista		FEB 1 7 2005		L	15				

		•	1 - State Amend Item 5 Registrar	State of Ma per fh G	aryland / Depa 341 3-23-05	artment of tas rtificate	f Health and of Death	Mental Hyg	iene _{eg. No} ? () () {	06915
	Physicia		Decedent's Name (First, Middle, Lass Shirley	Gerhard	it.			2. Date of Deat Month February	Day Yes	3. Time of Death 7:15 AM M
	/Medic Examin		4a. Facility Name (If not institution, give Wicomico Nursing Hom	· · · · · · · · · · · · · · · · · · ·		4b. City, Tow Salis	n, or Location of De		4c. County of D	
	Funeral Director		216-12-8703	714 087 -	e (In yrs. last birthday) Yrs.	If Under 1 Ye Months Da			9. (21	Birthplace (State or Foreign Country) Maryland
	a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomi	co	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	3a or 28	I Director	10e. Street and Number 900 Booth St.			10f. Zip Coo	₁₀ 21801	1	og. Citizen of What USA	Country?
0000	ivihin 72 hours after death with the Maryland jiene. Then "natural", or Items 23e or 28e-f ehow the Madical Examination natitied at	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No	Was Decedent If Yes, specify (1 ☐ Yes 2 dent's Usual Oc	Suban, Mexican, Pui No <i>Specify:</i>		14. Race - A Black, W Specify:	white
01717	within bene. then	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12		(Give	kind of work do DO NOT use re	one during most of w	vorking	16b. Kind of Busine Educatio	•
Maryiana zizio-0050	be filed tai Hyg d othe event.	To Be C	17. Father's Name (First, Middle, Last) Herbert E. Adam	5			18. Mother's N Mary	ame (First, Middle, M Vane	Maiden Sumame)	
	s 1 and 2 should t Health and Mer tem 27 ie merke other traumatic		19a. Informant's Name/Relationship (7) William J. Brown/	•	n-law 241	4 STanv	vick Rd.,	Phoenix,	MD 21131	
	Page nent o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 1 □ Donation 5 □ Other (Specify)	Salisbury	matory or other 7 Cremat	ory 2/1	11/05	Salisbury	, MD
2	permit. Departr Importe eny inji		21. Signature of Funeral Service Linds (2) 23a. Parl 1. Enter the disease, or comp	every ((-) (J	01 Snow	v Hill Rd.	,Salisbur	y, MD 218	Association 304
	Physician /Medical Examiner pnuisi-transit pnuisi-transit	Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	a. Due to (or as c.	a consequence of): a consequence of): a consequence of):	0 7	HRIVE			Interval Between Onset and Death
T.C. DOX 001.0.1	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregodnt in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal death 3	⊒Ectopic pregna			23d. Date of Month	delivery Day Year
L (cm)	quires that n signed b ald be deta	þ	Part II. Dther significant conditions o	ontributing to death b	ut not resulting in the u	inderlying cause	a given in Part I.			e to the cause of death? Probably 4 🛈 Unknown
or vital Records,	The law require ste hes been signage 2 should b	Completed	HYPOTHYROIDI	M				24a. Was a autops perform	y prior	
A II a	Physician: The this certificate he ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			0	eath (Check only on	re)	
DIVISION OF	ding Ph .r After th funeral	Certification; To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	ry 28b. Time o	of 28c.	Injury at Work? 1 Yes 2 No		ow injury occurred	pecity) Rural Route Number,
_	To the Hospitei or Attent within 24 hours after death To the Funerel Director: completely filled in by the	ledical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysician: To the best liner: On the basis o and manner st	of my knowledge, deal f examination and/or in ated.	th occurred at the	ne time, date and pla my opinion, death oc	ce, and due to the co	ause(s) and manner ate and place, and	as stated. due to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	1	ND	I	D-0060		9d. Date signed (M	onth, Day, Year)
	100	ate	30. Name and address of person who Mahesha Thimmarayap 31. Date filed (Month, Pay, Year)	a M.D. 614			sbury MD 218	04		

DHMH 16 Rev 6/95

Registrar

			FOR	State of Maryla				/lental Hyg	iene		
		1	- State Registrar		Cer	tificate of	Death		eg. No.	J5	06917
Phys	sicia	_	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Year	3. Time of Death
/Me	edica	al .	Marguerite Roselle Ia. Facility Name (If not institution, give str	Gilbert		4b City Town o	Location of Death	February	/ 18, 2 4c. County		9:15 P ^M
Exa	mine	r	Homewood Retiremen			William			Washi		
Fune	ral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,			ace (State or Foreign
Direct			220-16-3991	^{4 2} ♥ 9	4 Yrs.	Months Days	Hours Min.	June 4,	1910	Maryl	
pur 3			Usual Residence of Decedent 10a. State 10b. County	10c. 6	City, Town or Lo	cation				10	d. Inside City Limits
Aaryla f sho		.	Maryland Washingto		lliamsp						1 ☐ Yes 2 No
the 1		- ec	10e. Street and Number	11 11	TTTamsp	10f. Zip Code		1	0g. Citizen of \	What Counti	ry?
h with		O	10818 Wilcox Drive			21795	5		USA		
Larylanic A 1 A 13-0050 2 should be filad within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than anatural, or Items 23a or 28a-1 show the many than 1 and		Funeral Director	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (San, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America ck, White, et	
s after, or It		by Fu	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 □Yes 2V No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:		Specif	y. White	9
hours af			15. Decedent's Educa	Year or Dates:	16a. Deces	dent's Usual Occup	pation		16b. Kind of B		
in 72	18.80	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of world)	king			,
Z I Z d withiu giene. ar than		Completed	11	College (1-401 54)	Cashi	er			Groce	гу	
Id be fils ental Hy ked othe	N A	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, i			
Via Ment Ment		ဝ	Harry Milton Garlin	_	T-22 - 22 - 24 - 24		· · ·	Josephi	<u>·</u>		0.71
Mar d 2 sh th and th and 7 ts m	8	П	19a. Informant's Name/Relationship (Type Cherry L. Fox - Gra			ng Address (Street		villiams:			
a a a		-	20a, Method of Disposition			sition (Name of matory or other place			20c. Location		
ages ont of t: If it	5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			natory or other plac g Cremat		19.2005	Smithsb	ura.Ma	arvland
Baitimore permit. Pages 1 Department of H Important: If Ite	in oi	H	21. Sign vire of Funeral, ervice Centre			2. Name and Addre					
	and and		1 in Al &	Na	42	25 S.Cono	cocheague	e St. Wi	illiams	port,	MD 21795
			23a. Part1. Enter the disease, or complic shock, or head failure. List only one	ations that caused the de							Approximate Interval Between
Priysic	ian		Immediate Cause (Final disease or condition	MALL	sum (run				la la	Onset and Death
/Medi Exami			resulting in death)	Due to (or as a cons	sequence of):						
Lxum		<u>_</u>	Sequentially list conditions, b.	Due to (or as a cons	sequence of):						
bet _	USIE	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
D, execu	ial-Ita	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):						
58760, icate be executed physician and	and et	dical	d.								
rtifica ing ph	a as II	Med	IF FEMALE:								-
Box 6 eath certific attending p	or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pre	etal death 3	Ectopic pregnanc	у			ate of deliver onth	r y Day Year
he de	ped	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	ordeath 5t	Other (specify) _					
hat if	detac	/ Ph	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
Records, P	ed bi	d by	STROKE	HADENTE	MUN			1□Y	es 2□No	3 🗆 Proba	ably 4 Onknown
N rec	shou	siete		•				24a. Was a		Were autop	sy findings available appletion of cause of
Rec The lav	age	Completed						autop: perfor	med? 20 No	death?	
	ctor, p	BeC	25. Was case referred to medical examiner?					ath (Check only or	ne)		
Of V Physic this ce	dire	To	1 ☐ Yes 2 ☐ No		2 ☐ ER/Outpatie	nt 3L DOA		ome 5 Resid)
ing P	unera	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	Wo	ryat rk?]Yes 2 □ No	28d. Describe h	ow injury occu	rred	
Division of t or Attending Phys after death. Director: After this	/ the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place ol Injury - A	At home, farm, st		1103 2 110	281. Location (S	treet and Num	ber or Rural	Route Number,
Div after Direc	d in b	Certification:	4 Homicide determined	building, etc. (Sp	ecify)			City or Tow			
Division of Vita Volta Whysician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	completely filled in by the funeral director, page			ician: To the best of my							
in 24 in 64	pletei	edical	(Check only 2 Medicel Exeminate)	and manner stated.	iii auon and/or ir						
To t	COU	Σ	29b. Signature of the officer	Uk mice	1	29c. Licen	se number		29d. Date signi	ed (Month, L	Jay, Year)
73			Men	with the 1	natign	1 1)	(/00)		_{[]	7/00	()
3			C-COVER CETURE	mpleted cause of death (Item 23a) (Type	> /kla TH	our All	= H	665TO	Dani	Mod
	Sta	ite	31. Date liled (Month, Day, Year)	32. Hagistrar's S	ignature .	10010			J10	5-	1
Re	aist		FEB 2 2 20	15 1	M. A	nertis				611	47

	_		1 - For State Registrar				/ Depa		t of H	ealth a	and M		giene Reg. No	200	5 01	5918
	Physici	an	Decedent's Name (First, Middle	Last)								2. Date of Dea Month	ath Day	y Year	3. Time	of Death
	/Medi	cal	Ruby Ilene	Gates							10	Februar				5 A. ^M
	Examir	ner	4a. Facility Name (If not institution,		nd number)					Location of				County of De		
	Funeral		2938 Thurston 5. Social Security Number	Koad 6. Sex	7. Age	(In vrs. las	st birthday)	If Under		erick If Under		8. Date of Birt		Freder		or Foreign
	Funeral Director		229-52-3045	1 □ M 2	X F	64	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Septembe	y, Year) er 7	. 1940	irthplace (State Country) West V	iroini
	P.		Usual Residence of Decedent		`											
	arylar show	_	10a. State 10b. County				Town or Lo								10d. Inside	
	8a-f	ecto		erick		Fre	deric									s 2 No
	with t	ä	10e. Street and Number 2938 Thurston R	n a d				10f. Zip	1704					izen of What (Country?	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ra Madical Examirer must be multified at	Funeral Director	11. Mantal Status		s Decedent E	ver in U.S.	13.1				gin? (Spe	ecify Yes or No	U.S	• A • 14. Race - Ап	nerican Indian	
(0	ifter d	FE	1 □ Never Married 2 Marri	Am ed 1	ned Forces? Yes 2 N		1				i, Puerto	ecify Yes or No Rican, etc.)		Black, Wh		
93	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Y	es, Give ar or Dates:			1□Yes 2	2 No	Specify:			ĺ	Specify:	white	
5-0	72 hc	Completed by	15. Decedent (Specify only highes	s Education	leted)		16a. Dece	kind of wor	rk done d	lurina mosi	t of worki	ina	16b. K	ind of Busines	s/Industry	
121	vithin ne. han	mpi	Elementary/Secondary (0-12)	T	lege (1-4or 5-	+)	life.	DO NOT us	se retired,)			_			
2	filed withi Hygiene. other than		9 17. Father's Name (First, Middle, I	astl			bus	Drive	r	18 Mothe	are Name	e (First, Middle,		nsporta	ation	
an	d be t	o Be	John H. Crocke									fletche		Julianiej		
Maryland 21215-0036	2 should be finand Mental Fis marked of	2	19a. Informant's Name/Relationsh	ip (Type, Pri	nt)		19b. Mailir	ng Address	(Street a			al Route Numbe		r Town. State.	. Zip Code)	
S	nd 2 sith a sith		Frank Gates	Husbar		_						derick,			21704	
Je,	s 1 and of Health item 27 othar tr		20a. Method of Disposition			20b. Plac	ce of Dispo	sition (Nan	ne of	a)		Date	20c. Lo	ocation - City o	or Town, State	
E	Pages nent of i		1 1 1 1 2 1 1 2 1 1 Cremation 1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		I from State		haven				2-16-	-2005	Free	derick,	, Maryla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	censee -	. /	In-	22	2. Name an	d Addres	s of Facilit	y Sta	uffer I				
8	8989		Bharow Cl	mul	le Ci	len						e, Fred				21702
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications only one caus	that caused to e on each line	the death. e.						•	rest,		Approxima Interval Be Onset and	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	Adv	ance	ed	Bree	st	Co	uce	-			4 76	ears
	/Medical Examiner		resulting in dealin)		ue to (or as a	conseque										
		- a	Sequentially list conditions, if any, leading to immediate	b	ue to (or as a	conseque	nce of):									
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events				ŕ									
Ć,	exec in and inal-tra	Exa	resulting in death) Last	C	ue to (or as a	conseque	nce ol):									
68760,	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical		d												
99	rtifica ng ph s as th	Med	IF FEMALE:	7-27											1	
Вох	death certifica attending pt d for use as t	an/I	23b. Was decedent pregnant in the past 12 months?		es, outcome o			Ectopic pr	egnancy				:	23d. Date of de Month	elivery Dav	Year
	the at the diffe	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown]Pregnant at t]Unknown	ime of dea	th 5 □	Other (sp	ecify)					MOITH	Day	real
P.0	that the de ed by the detached		Part II. Other significant conditio	ns contribution	ng to death bu	t not resulti	ing in the u	nderlying c	ause nive	n in Part I		23e. Did to	obacco u	ise contribute	to the cause of	death?
Records,	signed d be de	d by			eilur.		· · · · · ·	,	g			101		·4	Probably 4	
202	w require been si should I	Completed	1 to Da	N- 4	ory F	-	WO					24a. Was	20	24h Were s	autopsy findings	e available
Re	he lav e has age 2	dmc	Acute F3	Pira			0-13-	•				autop perfo	rmed?	prior to death?	completion of	cause of
Vital	an: T ifficati or, pa	e C	25. Was case referred to medical							26 Place	of Death	1 ☐ Yes	22 No	1 ☐ Ye	s 2 No	
<u>></u>	Physician: The Is this certificate har ral director, page 2	To B	examiner? 1 ☐ Yes 2. No	Hospital	: 1 Inpatien	ıt 2□EF	VOutpatien	it 3 🗆 DO	A Othe	· ·	rsing Hor			6 □Other (Sp.	ecify)	
lof	T = E		27. Manner of Death 1 Matural 5 □ Pending		Date of Injury (Month, Day	/ 2	8b. Time of		8c. Injury Work			28d. Describe h			00.197	
<u>io</u>	Attendir death. ctor: Af y the fu	atic	2 ☐ Accident investig	ation				М		res 2□l	No					
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		Place of Injurbuilding, etc.	ry - At hom (Specify)	e, farm, str	eet, factory	, office		2	28I. Location (S City or Tox			Rural Route Nui	nber,
	urs af urs af eral D															
	Hos 24 ho Fune stely f	Medicai	29a. Certifier 1 Cartifying (Check only 2 Madical 8	xamınar: Or	To the best of the basis of a d manner stat	examinatio	edge, death n and/or in	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurr	and due to the o ed at the time, o	cause(s) date and	and manner a place, and du	as stated. ue to the cause((s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Mec	29b. Signature and title of certifier	an	amioi stat			29c	. License						nth, Day, Year)	
	->-0		1 KM		~ /	Im	0	D	4	18	66	5	Feb	ruary 1	4,200	20
	0,		30. Name and address of person v	vho complete	d cause of de	ath (Item 2	.3a) (Type,	Print)								
	`		Karan Hudhud	IMD						Drive	e (1	- reder	J'Ck	mo	2170	2
	Sta		31. Date liled (Mont Pap Year)	6 2005	32. Popistra	r's Signatur		hood	9							
	Regist	ai			and a	-	College Control									

			1 _ State		artment of Health ar tificate of Death	nd Mental Hy	2000	0000
181	· (c.		Registrar 1. Decedent's Name (First, Middle, Last)	001	incate of Death	2. Date of De		3. Time of Death
	Physicia /Medic		MARION L. GRAY			Februa	ry 10 200!	5 10:55P™
	Examin		4a. Facility Name (If not institution, give street and numi		4b. City, Town, or Location of I Salisbury	Death	4c. County of Deat	
	Funeral		Wicomico Nursing 5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year If Under 24		th 9. Bird	nplace (State or Foreign
	Director		029 - 16 - 8833 ^{1□ M 2} √√ F	79 Yrs.	Months Days Hours	Min. 9-13-1	925 MASS	ÄCHUSETTS
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	ith the Marylar or 28a-f ehow	tor	MARYLAND WICOMICO	SALISBUR	Y			1 Yes 2 No
	or 28.	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
	s 23a	eral	900 BOOTH STREET	lent Ever in U.S. 13. \	21802	2/5	US 14. Race - Ame	riana la dian
000	s i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Great is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event. It a Medical Exam is a routed by notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 및 Widowed 4 □ Divorced 12. Was Deced Armed Force 1 □ Yes 2 If Yes, Give Year or Dat	es?	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, § I ☐ Yes 2X No Specify:	Puerto Rican, etc.)	Black, White	
5	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	tent's Usual Occupation	f working	16b. Kind of Business/	industry
7	within no.	mple	Elementary/Secondary (0-12) College (1-4	40r 5+)	kind of work done during most o OO NOT use retired)		1101-7	
7 2	Hygie other	0	11. Father's Name (First, Middle, Last)	HOMEMA		Name (First, Middle	NONE , Maiden Sumame)	
g	2 should be filed within and Mental Hygiene. ie marked other then aumatic event. La Ma	To B	ERNEST LEMIEUX		MARY	ANNE JILCO	DINE	
Na.	0.00		19a. Informant's Name/Relationship (Type, Print) JOYCE JAQUITH/ DAUGHTER		g Address (Street and Number of CEMETERY ROAD			
ש	es 1 and 2 of Health a litem 27 ie r other trau		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date	20c. Location - City or	
5	Pages nent of I int: If its iry or o		1 Burial 2 □ Cremation 3 □ Removal from St 4 □ Dopation 5 □ Other ₃ (Specify)	ST. GEORG	natory or other place) E'S CEMETERY 2/	14/05	CLARKSVILLE	
	permit. Pages I Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Services en 44	MI TI	ELSON FUNERAL S HATCHER STREET,	ERVICES,L'	TD. D, DE. 19945	5
П			23a. Part1. Enter the disease, or complications that can shock, or heart failure list only one cause on ear	used the death. Do not ent	er the mode of dying, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	POXIA				Oriset and Death
	Examiner		Due to (o	r as a consequence of):				
H	D #	ner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying	r as a consequence of):				
	and and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o	r as a consequence of);				
,00,	icate be executed physician and s the burial-transit	dicalE	335,6,6	r as a consequence siy.				
0	rtificate ng phy as the	60	U		:			
O. DOX	The iaw requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	Physician/M	in the cast 12 months?	nt at time of death 5 □	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ŗ	that the sed by detac		Part II. Other significant conditions contributing to dea	ith but not resulting in the ur	nderlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
cords,	quires an sign	ed by	LUNG CANCER			11	Yes 2 □ No 3 □ Pro	bably 4 Dunknown
၁ ၁	lawre as bed 2 sho	Completed	TYPE 2 DIABETES	•		24a. Was		topsy findings available ompletion of cause of
ב ב	r: The		CONGRETIVE HEAR	T FAIL	URE		rmed? death?	2 D No
A II d	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \subseteq \text{No} \) Hospital: 1 \(\subseteq \subseteq \text{Inj} \)	patient 2 ER/Outpatien		Death (Check only o	one) dence 6 □Other <i>(Spec</i>	Z.,
5	Attending Physician: The law required death as the far that this certificate has been s rector. After this certificate has been s by the funeral director, page 2 should	-	27. Manney Death 1 Death 28a. Date of (Month,		28c. Injury at Work?		how injury occurred	ny)
	tendir leath. tor: Af the fu	catle	2 Accident investigation		M 1 Yes 2 No			
5	al or Attendir s after death. ii Director: Al	Certification:	determined 286. Place 0	of Injury - At home, farm, strong, etc. (Specify)	et, factory, office	28f. Location (City or To	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	is of examination and/or inv	occurred at the time, date and prestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	, Day, Year)
			Milliani	100	D 0060	515	4/1/6	25
H	1.4		30. Name and address of person who completed cause Mahesha Thimmarayapp	a, MD 614	Print) Easternshor	e Dr., S	alisbury,	MD 21804
	Sta Registr		31. Date filed (Month, Pag Year) 4 2005 32.	gistrar's Signature	ande			

o		1 - State Amend It Registrar		per br., d	Centil	icate of t	Death	d Mental Hy	Reg. No.	2000	
Physic	ian	1. Decedent's Name (First, Mid	idle, Last)				_	2. Date of D	eath Day	Z U Vear	3 Time of Death
/Medi		Sherry	F.	Gilyard				Februa	- 1	3,2005	
Exami	ner	4a. Facility Name (If not institut		mber)	41	o. City, Town, or		Death	4c. (County of Death	1
		5205 Eastbu		7 4 - 11 11	tiat to N I	Baltim Under 1 Year		Hea I a a si da			
Funeral Director		5. Social Security Number 184–44–7561	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last 53		onths Days		Hrs. 8. Date of B (Month, D Sept.1	ay, Year)	Coi	nplace (State or Foreig untry) 1 and
P .		Usual Residence of Decedent									
arylar show	_	10a. State 10b. Coun	nty	10c. City, To	own or Locati	on					10d. Inside City Limit:
88-f	cto	Maryland		Balti	imore						1 Pres 2 □ N
vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?
s 23s	ra	5205 East1				21206				USA	
er de Item	Funeral Director	11. Marital Status	Armed Fo		13. Was	Decedent of Hi s, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0- 1	 Race - Amer Black, White 	
rs aft	by F	1 Never Married 2 M 3 Widowed 4 Divorce	If Yes Gir	ve '	1 🗆	Yes 20HO	Specify:			Specify:	
72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show Jisal Enatur at must be swilfled at	ed		ent's Education		6a. Decedeni	's Usual Occupa	ation		16h Kin	BI d of Business/l	ack
within 72 ene. then "na	Completed	(Specify only high Elementary/Secondary (0-12	hest grade completed) College (**		(Give kind	d of work done o NOT use retired	luring most of	working			
d with	mo	Liethernary/Secondary (0-12	4	1-401 34)	Teac	ner			Boa	rd of E	ducation
be tiled ital Hygi id other event, t	Be C	17. Father's Name (First, Middl	le, Last)				18. Mother's	Name (First, Middl	e, Maiden S	Sumame)	
uld b Aentz rked ric e	To E	Davis W. (Gilyard, Sr				Char	clotte S	ampso	n	
should and Men s marke	ľ	19a. Informant's Name/Relatio	nship (Type, Print)	1	9b. Mailing A	ddress (Street a	and Number o	r Rural Route Numi			ip Code)
and 2 salth n 27 l		Davis W. Gily	yard, Sr. /				Ave.,	Reading	Pa.	19606	
- I a =		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Demoval from		of Disposition	n (Name of bry or other place	9)	Date	20c. Loc	ation - City or T	Town, State
Pages ment of I ant: If It ury or o		'4 □Donation 5 □ Other			New Ma	arket Ce	em. 02-	-19-2005	East	New Ma	rket.Md.
permit. Departr Importa any inj		21. Signature of Funeral Service	os Lio Har		22. N	ame and Addres	s of Facility				
8 A E 8 A					> 51	S. Ma	in Stre	eral Home	e ock,Ma	arvland	21643
		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that dist only one cause on e	aused the death. Deach line.	o not enter the	ne mode of dying	g, such as car	diac or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		onges	tive	Cal	-dio	my op.	+ 4.	4	Onset and Death
/Medical		resulting in death)	Due to	(or as a consequence				10	- (
Examiner		Sequentially list conditions,	b								
p #	Examiner	if any, leading to immediate cause. Enter Under in	Due to	(or as a consequent	ce of):						
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icate be executed physician and s the burial-transit	dicai Ex	that initiated events	cDue to	(or as a consequenc	ce of):						
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		For State Registrar	State of Mary		artment of rtificate of			Reg. No	05 0592
Physicia /Medic	al .	Decedent's Name (First, Middle, La Eulandolyn	Jone	:S	Hai]			ry 9, 20	
Examin	er	4a. Facility Name (If not institution, giv Holy Cross Hospi				or Location of De	ath	4c. County	
Funeral		5. Social Security Number 6. S		yrs. last birthday)	_ If Under 1 Yea				9. Birthplace (State or Fore Country)
Director		427 13 9801	□M 2XXF	9 Yrs.	Months Days	s Hours M	n. (Month, Da Nov. 8		Country) Mississippi
2 *		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	· · · · · · · · · · · · · · · · · · ·		1011		
/z nous arier bean win ne maryano natural', or Itama 23a or 28e-f show dical Examinar must be notified at	5	Tob. County	100	City, Town or LC	ocation				10d. Inside City Lim 1 ☐ Yes 2 👿
28e-f	Director	Maryland Prince 10e. Street and Number	Georges	Beltsvil	1e 10f. Zip Code			10g. Citizen of V	
penill. Tages I allo as bround by ligione. Important: If I than It's marked other then "natural", or I lams 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ö	3619 Shenandoah D	rivo			20705			
ms 2	Funerai	11. Marital Status	12. Was Decedent Ever	in U.S. 13.			(Specify Yes or No erto Rican, etc.)		JSA a - American Indian,
or Ita	F.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1	1 Tes, specify Cu		erto Hican, etc.)		k, White, etc.
IFXE	Completed by	3 Widowed 4 Divorced	Year or Dates:		7 165 XX	э эрөспу.		Specify	Black
nati	lete	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occu	e during most of v		16b. Kind of Bu	siness/Industry
then "	щ	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir	DILECT		_	d Department
Hygi othar ent, t	0	17. Father's Name (First, Middle, Last	5 +	⊥неатт	h & Mino	18. Mother's N	airs ame (First, Middle,	of Educ Maiden Sumam	
kad c	To B	Elmer Lamar Jon	es			Emma	Jean	Howar	d
nnd Men marka	_	19a. Informant's Name/Relationship (19b. Mailin	ng Address (Stree		Rural Route Numbe		
n 27 le		Alan Haile / Husb	and	3619	Shenando	ah Drive	Beltsvi	lle, Mar	yland 20705
P F F		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐	Pomoval from State	Ob. Place of Dispo cemetery, crei	osition (Name of matory or other pl	ace)	Date	20c. Location -	City or Town, State
nent of l		*4 □Donation 5 □ Other (Special	71 (911)Oval (Cott) Gtate	xford Ce			14/2005	Oxford.	Lafayette, M
Departr Imports any inju		21. Signature of Funeral Service Lice		22	2. Name and Add	ress of FacilityH	ines Rina	ldi Fune	ral Home
CQE 2 9		Town & N	embr.	11	800 New	Hampshir	e Ave Si	lver Spr	ing,MD 20904
Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Obisease or injury	a. Liver Fai Due to (or as a con Due to (or as a con	nsequence of): c Breast	Cancer				2 Months 3 Years
iding physician and ise as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	nsequence of):					
or u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnant Other (specify)	су		23d. Date Mor	e of delivery hth Day Year
been signed by the s	by	Part II. Other significant conditions	contributing to death but no	t resulting in the u	inderlying cause g	iven in Part I.			ibute to the cause of death
2 sh	Completed						24a. Was		Vere autopsy findings availa
<u> </u>	mo							rmed? d	rior to completion of cause leath? □ Yes 2 ∑ xlo
	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		
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certific rector.	ř	07 Manager of Decah	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	f 28c. Inj	ury at ork?		now injury occurre	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Day, Year)

FEBRUARY

REGIONAL MEDICAL CENTER. MD 21081

Physician
/Medical
Examiner

Funeral Director

the Manyland "neturel", or items 23a or 28a-f show oleal Examiner must be notified at 72 hours after death with 27 is marked other then "netu traumatic event, the Madical 12 should be filed within 72 h and Mental Hygiene, "n 7 ie marked other then "n permit. Pages 1 and 2 sh Department of Health and important: if item 27 ie m any injury or other traum once.

Baltimore, Maryland 21215-0036

ANNA HOWARD

leted by Funeral Director

Compi

Be 2

Pnysician /Medical Examiner

Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical 5 Completed by this After thi Certification: death.

Box 68760. P.O. I Records, Division of Vital Hospital or Attending Director: hours after within 24 hours at To the Funeral D completely filled i 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 8-33 AM FEBRUARY09 Will Anna Howard 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Peninsula legimal Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Center WILDMICO 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 💢 F Yrs. 174-18-9321 85 1919 Alabama 27 Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Olivia Street 21801 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alter Howard Sr. Annie Rhett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 W.North Ave.Pittsburgh Pa.15212 Mary Walker (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 2-15-05 Green Acres Salisbury, Md. 22. Name and Address of Facility
Stewart Funeral Home 21. Signature of Funeral Service Licenses Stewart Hladus B. 821 West Rd.Salisbury, Md. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIALINFARCTION ACUTE I D AY Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check onli one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Registrar

Medical

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB I 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHIRAZI, M.D. PENINSULA

Elever & Spark

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D46962

		1 - For State of Maryland / Department of Health and No. Certificate of Death		giene 200	06923						
Physi /Mec Exam	ical	1. Decedent's Name (First, Middle, Last) James A. H	2. Date of Dea Month	Day Year 200 : 4c. County of Dea	th						
Funera Directo		5. Social Security Number 222-10-0181 Coastal Hospice III the Lake 5 al: 5 bury 7. Age (In yrs. last birthday) 1 Tyrs. 1 Tym 2 F 84 Yrs. Wonths Days Hours Min. A Usual Residence of Decedent	8. Date of Birth (Month, Day	(Year) Co	thplace (State or Foreign DELAWARE						
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. Ind thygiene. Indicate than "natural", or teems 23a or 28a-f ehow event, the Madical Examinar must be neithfied at	Funeral Director	10a. State 10b. County 10c. City, Town or Location MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 21804 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	Og. Citizen of What Co							
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Maryland 2 Id 2 should be filed th and Menta Hygi 27 is marked other traumatic event, It	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Nam	ne (First, Middle, I	₹	Zip Code)						
more, Pages 1 an ent of Heal nt: tf Item?		JUANITA D. HILL WIFE 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ODD FELLOWS 427 VALLEYWOOD DR. 20b. Place of Disposition (Name of compatent) or other place) 1 Burial 2 Cremation 3 Removal from State ODD FELLOWS 427 VALLEYWOOD DR. 20b. Place of Disposition (Name of compatent) or other place) CEMETERY 2/16	SALISBU Date /05	JRY, MARYL 20c. Location - City or SEAFORD,	AND 21804 Town, State DELAWARE						
Provinciant //Medica Examine	Examiner	WATSON-YATES FI SEAFORD, DELAW 232 Part1. Enter the discrete, or complication, that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Nicretail and Cause) Bue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ARE 199	973	Approximate Interval Between Onset and Death						
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148	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAVID OUALL, MD F.O. Box 1733 Solis	3	2-/ NS 2	4-05 1801						
Regis	tate trar	31. Date filod (Month, Day, Year) 2005 32. Registrar's Signature fresh	9,								

Second Security Number 428 - 30 - 6952 10 M 32 F 7. Age (in yrs. fast brinday) 100. City, Town or Location of Deader 100. State 100. County 100. City, Town or Location	2005 06021
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The state of the s	se contribute to the cause of death?
The state of the s	No 3 Probably 4 Unknown
27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 3 Suicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Publishing at Carpeting)	24b. Were autopsy findings available prior to completion of cause of
27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury At home, farm, street, factory, office	death? 1 ☐ Yes 2 ☐ No
27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury At home, farm, street, factory, office	
U	
2 Accident Investigation 2 Accident Investigation 3 Suicide 4 Homicide 4 H	occurred
Dilliding, etc. (Specify)	Number or Rural Route Number,
29a. Certifier (Check only (Ch	and manner as stated. place, and due to the cause(s)
one) and manner stated. 29c. License number 29d. Date	e signed (Month, Day, Year)
E. P. Irline M.D. D09470 2/11	./05
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, MD 10901 Connecticut Avenue, Kensington, Maryla	
State Registrar 31. Date filed (Month, Pay, Year) 5 2005 32. Resistrar's Signature	

			1_ State	artment of Health and Mental I Intificate of Death	
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. f Death Day Year 3. Time of Death
	Physici		CECELIA EVE HERSBERGER	FEB.	12 2005 11:10A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			9704 INAUGURAL WAY	MONTGOMERY VILLAGE	MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month	f Birth , Day, Year) 9. Birthplace (State or Foreign Country)
	Director		578-22-8763 88		7 1917 MD
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation	10d. Inside City Limits
	Many f sh	ρ	MD MONTGOMERY MONTGO	MERY VILLAGE	1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with	al D	9704 INAUGURAL WAY	20886	USA
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28e-f show the Madical Exeminer must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	Specify: WHITE
Maryland 21215-0036	72 hou natura	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b. Kind of Business/Industry
7	도 . c 문	nple	Elementary/Secondary (0-12) College (1-4or 5+) LOAN	e kind of work done during most of working DO NOT use retired) J PROCESSOR	INSURANCE
121	illed with Hygiene other tha		12 17. Father's Name (First, Middle, Last)		
and	d a la la la la la la la la la la la la l	To Be	HARRY ALLNUTT DRONENBURG	18. Mother's Name (First, Mic SARAH WHI	
ary.	2 should and Men is marks	F	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Rural Route Nu	ımber, City or Town, State, Zip Code)
	th a tra		BARBARA HERSBERGER/DAUGHTER 960	1 OYSTER PT. WAY, M	ONTGOMERY VILLAGE, MD 20886
ore			20a. Method of Disposition 20b. Place of Disposemetery, cemetery, emetery, cemeter, cemeter,	imatoni or other place)	20c. Location - City or Town, State
Baltimore,	Pa Fig.		· 4 Donation 5 Other (Specify)	Y CEMETERY 2/19/05	BEALLSVILLE, MD
Ba	permit. Departrimports any inju		H ALLONDON	2. Name and Address of Facility ILTON FUNERAL HOME .O. BOX 86, BARNESV	ILLE, MD 20838
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respirato	ry arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1)	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		7
	Examine	J.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury		
,	execu n and ial-tra	Examiner	that initiated events c		
68760	te be executed ysician and e burial-transit	edical	d		
	rtificate ng physi as the l		IF FOLIAL C		
Вох	attending	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1	□Ectopic pregnancy	23d. Date of delivery
O. E	at the dea by the at tached fo	Physician/M		Other (specify)	Month Day Year
Ф	that the		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I 23e [Did tobacco use contribute to the cause of death?
Records,	Se CB ec	d by			Yes 2 70 3 Probably 4 Unknown
CO	aw require as been sla 2 should l	Completed			Vas an 24b. Were autopsy findings available
R	The la	mo:		a p	utopsy prior to completion of cause of death? es 2 \(\begin{align*} \text{No} \\ 1 \end{align*} \text{Yes} 2 \(\end{align*} \text{No} \)
Vital	ician: T certificet rector, pa	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)
of V	Physician: this certific ral director,	0	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursing Home 5 F	Residence 6 Other (Specify)
	tter nen	lon:	27. Manner of Death 1 Manual 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	ibe how injury occurred
isic	Attanding r death. actor: After by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not be determined to the determined and the determined to	M 1 Yes 2 No	on (Street and Number or Rural Route Number,
Division	tal or Attandil s after death. al Diractor: A ad in by the fu	Certification:	4 Homicide determined building, etc. (Specify)	City or	Town, State)
	Hospital 24 hours a Funeral C		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deat (Check only 2 Medicel Examiner: On the basis of examination and/or in	th occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To the Hospital or vithin 24 hours after Youhe Funeral Dirac completely filled in b	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	T Will		P P D DAD IN		
,	X		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) J17 L7	125000 11,200
			(John R. Melnich- 911)	mirel me Gaithe	felmany 14,2005
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6 2005	to the second	-

			1 - For State Registrar	State of I	Maryland / De _l	partment of Fertificate of	lealth and N Death		iene 005	06926
:24:	Rich		1. Decedent's Name (First, Middle,	Last)				2. Date of Death	h	3. Time of Death
	Physicia /Medic		Mary	Jackson				Feb.	Day Year 06 2005	2:00 P M
	Examin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Town, o	r Location of Death		4c. County of Dea	th
			Holy Cross Hosp				Spring		Montgome	ery
	Funeral		5. Social Security Number 6	. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birthda 85 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bii	thplace (State or Foreign ountry)
	Director		578-20-5882 Usual Residence of Decedent	-	65 113.			Dec. 28	1919 MA1	yland
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar.	ţō	D.C.		Washi	ngton				1 ⊈Yes 2 ☐ No
	or 28	ire	10e. Street and Number	-		10f. Zip Code		10	0g. Citizen of What C	ountry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow tha Modical Examinat must be notified at	Funeral Director	26 Sherman Ci	rcle N.W.		2001	.1		USA	
	tems	nuel	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 1: es?	 Was Decedent of H If Yes, specify Cub 	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	₹No	1 ☐ Yes 2 🔀 No	Specify:		Specify: B]	
21215-0036	hour		15. Decedent's	Year or Date		cedent's Usual Occup	nation		16b. Kind of Business	
7.	n "na	plet	(Specify only highest	grade completed)	(Gi	ve kind of work done . DO NOT use retire	during most of work	king	TOD. KING OF BUSINESS	viridustry
212	d with giene r tha	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	Seamstres	S		U.S. Gover	nment
פ	othe vent,	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)	-
/lai	Menta Menta arked	<u>ا</u> م	Henry Thomas				Adaway	Curtis		
Maryland	and and ls mu		19a. Informant's Name/Relationshi Betty Williams						City or Town, State,	
2,	and lealth m 27 her tr								gton, D.C.	
altimore,	ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, Ite Madical Examiner must be notified at		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	B □Removal from Sta	ate cemetery, c	position (Name of rematory or other pla	ce)		20c. Location - City or	r Town, State
ţ	trant rtant		'4 □Donation 5 □ Other (Spe		Fort Li		02-12		Brentwood,	
Bal	Department of the population o		21. Signature of Funeral Service Li	o no					Funeral H	
			23a Part Enterthe disease or o	amplications that cau					on, D.C.	20011 Approximate
			23a. Part . Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final				19, 30011 03 0010100	or respiratory arre	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-	ation Pneum as a consequence of):	onia				
	Examiner			Bacter						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Under in	D	as a consequence of):					
	cuted id ansit	Examine	Cause (Disease or injury that initiated events	Cerebi	cal Vascula	r Accident	t			
ó	an ar	EX	resulting in death) Last	· ·	as a consequence of):					
8760,	ficate be executed physician and s the burial-transit	dlcal		d. Multi-	-Infarct De	mentia				
9	artifica ing pl	0 1	IF FEMALE:							
Вох	death certific e attending p d for use as f	Physician/M	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal death	B Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
<u>o</u> .	t the de by the a tached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Pregnar 9□ Unknow		5 ☐ Other (specify) _				,
<u>α</u>	that the by detac		Part II. Other significant condition	s contributing to deal	th but not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
ds	uires sign ld be	d by						1 □ Ye	s 2 No 3 P	robably 4X Unknown
Ö	w requir been si should	lete						24a. Was ar	n 24b Were a	utopsy findings available
Records,	The law requires ate has been sign page 2 should be	ompleted			•			autops	y prior to ned? death?	completion of cause of
Vital		Ö	25. Was case referred to medical				26 Place of Dea	th (Check only one	^	s 2 No
<u>``</u>	Phyelcian: this certific ral director.	0	examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1 🔀 Inc	atient 2 ER/Outpa	ient 3 DOA Ott			nce 6 Other (Spe	acifv)
1 6¢		T :u	27. Manner of Death	28a. Date of		of 28c. Inju	ry at	28d. Describe ho		,
ioi	Attending r death. ector: After y the fune	atlc	1 Natural 5 Pending 2 Accident investiga	ition	,		Yes 2 □ No			
Division		Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Flace 0	Injury - At home, farm, , etc. (Specify)	street, factory, office		28f. Location (Sti City or Town	reet and Number or F n, State)	lural Route Number,
	urs af									
	Hospital 24 hours a Funeral C	edical	(Check only 2 Medical E	xaminer: On the bas	est of my knowledge, de is of examination and/or	eath occurred at the ti investigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Hospital or within 24 hours affe to the Funeral Dir completely filled in	Med	29b. Signature and title of certifier	and manne	r sidleu.	29c. Licens	se number	29	9d. Date signed (Mon	th, Day, Year)
	F 3 T 8		1	4					February 7	-
)	(2)		30. Name and address of person w	to completed cause	of death (Item 23a) (Tvi	1.00	0619	T	.cordary /	, 2003
	(3)		Connie D. L		1500 Fores		d Silver	Spring.	MD. 20910	
	Sta	atė	31. Date filed (Month, Day, Year)		jistrar's Signature					
	Regist	rar	FEB 1 6 20	05	W Ka	and a second				

Amended #18 mll, Amended #26 2 & 4 mll on 02/16/05, Allegany Co. 02/16/05, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene PER MD. Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Parrish Janeway Month **Physician** 10:30 A. February 13, 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give creet and sumber) Examiner Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 217-34-6553 6. Sex **Funeral** Months 1 □ M 2 💢 F 66 Director August 08, 1938 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-1 show if Health and Mental Hygiene. Itam 27 is marked other than "natural", or itama 23a or 28a-1 show other traumatic event, the Medical Extra par must be notified at Berkley Gerrardstown 1 XYes 2 □ No West Director Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 675 Persimmon Lane 25421 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White 9 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **Executive Director Human Services** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Pannell John Rodwell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Wolz/Friend permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any injury or other tra 54 Jackson Street, Lonaconing, Maryland, 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 14, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **Cumberland Crematory** Cuberland, Maryland 2005 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Miken 2 Eichhorn-McKenzle Funeral Home 8 East Main St., Lonaconing, Md. 21539 23a. P. C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melostot C UIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by disorder 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe page 2 1 Yes 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Hospital: 1 ☐ Inpatient 22 EP/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifies D0060478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mill Camboolund, Mary / And 21502 Ken 625 Alenur AHMAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 6 2005 DENER Registrar

			1 - For State Registrar	State of Ma	ryland		artment of tificate of				giene Reg. No.	200	5 0602
*	Physici /Medic		1. Decedent's Name (First, Middle, Las SHIRLEY E. JOHNS							2. Date of Dea Month 02	Day	Year 2005	3. Time of Death —
	Examin	-	4a. Facility Name (If not institution, give CAROLINE NURSING	,			4b. City, Town, DEN		of Death		4c.	County of Dea	
	Funeral Director		5. Social Security Number 6. S		(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day 12-26-1	y, Year)	9. Bir Ce MAR	thplace (State or Foreign buntry) YLAND
	ahow	ž	Usual Residence of Decedent 10a. State 10b. County		•	Town or Lo							10d. Inside City Limits 1√□ Yes 2 □ No
	th the M or 28a-f e cotifi	Funeral Director	MD CAROL 10e. Street and Number	LNE	FED.	ERALS:	10f. Zip Code				10g. Citi	zen of What Co	11
	s 23a	rai	309 ACADEMY AVEN	· · · · · · · · · · · · · · · · · · ·		40.4		21632				14. Race - Ame	USA
2-0036	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene. Act other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, Ve Medical Examinat must be notified at	b	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cul 1 ☐ Yes — ※☐ No			Rican, etc.)		Black, Whit	te, etc.
21215-0	within 72 ho ene. than "natur	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			16a. Deced (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during mos ed)	t of workii	ng	16b. Ki	nd of Business	/Industry
2	filed wi Hygien other th		12 17. Father's Name (First, Middle, Last)	2			NURSE	18 Mothe	ar's Namo	(First, Middle,		JRSING	HOME
auc		To Be	CLARENCE LEE TRAY							SCHULT		obmane)	
Mary	od 2 shoulth and N		19a. Informant's Name/Relationship (F. WAYNE JOHNSON	Type, Print)			ADAMS RO	t and Numbe	er or Rura	l Route Numbe	er, City o		
a)	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ce of Dispo	sition (Name of natory or other pla	1		ate		cation - City or	
	it. Pa rtmen rtant: njury		* 4 ☐ Donation 5 ☐ Other (Specifical Service Licery)		UNI		SHINGTON . Name and Addr						ARYLAND
Ba	permit. Departn Imports any inju		Thesis L	en Hell	ne	71	D5 EAST	MAIN S	TREE	T, SALIS	BURY		AND 21804
ı	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olcations that caused one cause on each lin	the death. e. Cat	Do not ent	er the mode of dy				rest,		Approximate Interval Between Onset and Death
39	/Medical Examiner		Due to (or as a consequence of):										
	scuted ind transit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	•	,							
8760,	ate be executed thysician and the burial-transit		Tessuing in death, East	Due to (or as a	a conseque	nce of);							
P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1	2 🗌 Fetal d	leath 3	Ectopic pregnand Other (specify)	ру			2	23d. Date of de Month	livery Day Year
ds, p	juires that n signed b	by	Part II. Other significant conditions of	ontributing to death bu	it not result	ing in the u	nderlying cause g	ven in Part I.	•		obacco u 'es 2[o the cause of death?
Records,	The law requirrate has been sipage 2 should I	Completed								24a. Was a autop perfor	Sy	24b. Were at prior to death?	utopsy findings available completion of cause of
Vita	ysicien: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospital:			_ 0			(Check only o			
ō	ding Phys h. After this funeral di	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injur (Month, Day		8b. Time of	t 3L DOA	4 BUNU		ne 5 Resid 28d. Describe h			city)
Division of Vital	i or Attending after death. Director: Afte	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	Injury ne, farm, str	Work? M 1 □ Yes 2 □ No			Street and	treet and Number or Rural Route Number,				
Ö	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide	building, etc		lodge does!		mo data an	d alass a	City or Tow			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Madical Exar	ninar: On the basis of and manner sta	examinatio	n and/or in	restigation, in my	opinion, dea	th occurre	ed at the time, o	date and	place, and due	o to the cause(s)
)	Tot With Com	2	29b. Signature and title of certifier	Sela	× 1	41	-	se number	6			e signed (Mont	
	29		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	/	- 100	uto	N ME	0	21/27	9
1	Sta Regist		31. Date filed (Month, Day, Your) 5	2005 32. Figistra	ır's Signatu		hadis		- 00	. 10		1100	7

		1 - For State Registrar		of Maryland	-		f Health a of Death		Re	ig. No.	05	06931
Physic /Med Exami	ical	Decedent's Name (First, Minerva. 4a. Facility Name (If not institution)	S, Ko			-	m, or Location	of Death	Date of Death Month	Day	Year OOS of Death	3. Time of Death 12:55P.M
Funeral Director		Levinda 5. Social Security Number 221-32-6813 Usual Residence of Decedent	6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Yo	fi'mor ear if Under ays Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day,	Year) 1910	Coun	lace (State or Foreign try) Adelphia, Ph
death with the Maryland ims 23e or 28a-f ahow froust be notified at	ector	DE New	Castle	· N.	ewar		do			Og. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 🔏 No
	Funeral Director	32 Tivert	Amed	ecedent Ever in U.S Forces?	5. 13.	19	702 of Hispanic Ori Cuban, Mexicar	igin? (Speci n, Puerto Ri		U. S	ce - Americ	an Indian,
21215-0036 In within 72 hours after giene. The medical Exercis.	þ		larried 1 ☐ Ye If Yes, Year o dent's Education thest grade complete	es 2 XNo Give r Dates:	16a. Dece	1 ☐ Yes 2 ☐ Adent's Usual Ockind of work do			,	Special Specia	y: Wh	
nd 2121 be filed within al Hygiene. d other than went, the Me	Be Completed	Elementary/Secondary (0-1 / 2 17. Father's Name (First, Midd	lle, Last)	e (1-4or 5+)		DO NOT use re	Ken 18. Mothe	er's Name (First, Middle, N		ne)	7<
Maryland of 2 should be fit the and Mental H. 27 is marked off traumatic even	Tol	Nathen 1 19a. Informant's Name/Relati Barbara R. D	onship (Type, Prin		19b. Mailii	ng Address (Sti	reet and Numb	er or Rural I	(Un Route Number,	City or Town	State Zin	Code)
Baltimore, sermit. Pages 1 ar Department of Hea mportent: if Item noy injury or othe		20a. Method of Disposition 1 ★Burial 2 □ Cremati 4 □ Donation 5 □ Othe	on 3 Removal fro	20b. Plane	ace of Dispo emetery, crei	esition (Name of matory or other	emety:	2/18	te /	Oc. Location	 City or To 	
Dermii Depar Impo		21. Signature of Funeral Serv 23a. Part 1. Enter the dis shock, or heart share.	lug,	arcaused the death.	3	-19 Ph	ddres f Facill 7 Cm 1666/ p dying, such as	This P	Ke, W respiratory arre	i'lmin	They D.	Approximate Interval Between
When the properties of the private reason and properties of the private reason and private reason and private reason and private reason are private reason and private reason and private reason are private reason are private reason and private reason are private reason are private reason and private reason are private reason and private reason are privat		Immediate Cause (madisease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	o (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequ	tive ience of):	He onc sews-	Can Can	100	asev.	lar)	Onset and Death (POLV)
BOX 6	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Liv 4 ☐ Pri	outcome of pregnar re birth 2 ☐ Fetal egnant at time of de iknown	death 3[∃Ectopic pregni ∃Other (specif)					ite of delive	ry Day Year
cords, P.O. w requires that the been signed by the should be detached.	by	Part H-Other significant con-	ditions contributing to	o death but not resu	ilting in the u	nderlying cause	e given in Part I	l.	23e. Did tob	1		e cause of death?
I Re	e Completed	.25. Was case referred to med	ingl				00 Pl	- d D - oth		red?	prior to cor death?	osy findings available inpletion of cause of 2 No
of Vita Physicien: this certific ral director,	To B	examiner?	Hospital:	☐ Inpatient 2☐ E	ER/Outpatier	nt 3 DOA	04		Check only one 5 ☐ Reside		ner (Specify	')
Division of I or Attending Phys after death. Director: After this I in by the funeral di	Certification:	Z C / Nooidont	nding (N estigation	fonth, Day Year)	28b. Time o Injury	М	Injury at Work? 1 Yes 2	No 28	d. Describe ho	w injury occu	red	
- 2 # F C		4 Homicide det	tying Physicien: To	ace of Injury - At hor illding, etc. (Specify,	")				City or Town	, State)		Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled i	edicai	(Check only Medi	cal Exeminer: On th	e basis of examinati namer stated.	ion and/or in	vestigation, in r	my opinion, dea	ath occurred	at the time, da	ite and place,	and due to	the cause(s)
To the within	W	29b. Signature and title of cer	ifier X			29c. Lio	cense number	13	29	2/17/	d (Month, I	Day, Year)
7		3 M e and address of per	eny	se of eath (Item	2ncA	all a	2434	Wi	Belve	lere	2	1215
S Regis	tate trar	34. Date filed (Month, Day, You	8 2005	2. Begistrar's Signat	B A	cook						

UNK 05-0845 AKG

		1 - For State Registrar					tificate of	lealth and N Death		Reg. No	ZUU	b	0693
Physicia		1. Decedent's Name (First, Midd Matthew Do	lle, Last) QVid	Krese					2. Date of De Month Februal		^y , 20ở	ear	3. Time of Deat 8:59 P
/Medic Examin		4a. Facility Name (If not institution			·)		4b. City, Town, o	r Location of Death			. County of		
		Forest Glen Me	etro S	Station			Silver	Spring		l l	iontgo		
neral		5. Social Security Number	6. Sex	7. A	ge (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th) 9	. Birthpla	ce (State or For
ctor		499-70-4647	I LAIN	7 2UF	46	Yrs.			April				ington,
2		Usual Residence of Decedent 10a. State 10b. County	/		10c. City, To	wn or Loc	ation					100	d. Inside City Lin
Examiner must be notified at	tor	Virginia Princ	e Wil	lliam	Woo	dbri	dae						1 🗆 Yes 2 🔀
100	lrec	10e. Street and Number	C WII	mum	7700	<u>ubi i</u>	10f. Zip Code			10g. Ci	itizen of Wh.	at Country	y?
	a D	13889 Langst	one L	Drive			22193			L	JSA		
	Funeral Director	11. Marital Status		. Was Decedent Armed Forces	Ever in U.S.	13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No)-	14. Race -		
	by	1 XNever Married _2 Mar 3 Widowed 4 Divorced	rried	1 Yes 2 If Yes, Give Year or Dates:	X _N o		□Yes 2X No	• 4			Specify: White		
	eted	15. Deceder (Specify only higher	nt's Educat	tion completed)	168	a. Decede	ent's Usual Occup	ation during most of work	kina	16b. K	Kind of Busin	ind of Business/Industry	
	Completed	Elementary/Secondary (0-12) College (1-4or 5+)							No	None			
	Be C	17. Father's Name (First, Middle,	Last)				'	18. Mother's Nam	e (First, Middle				
	To B	Paul Kres	e					Betty	Elizabe	eth	Elleb	rach	t
		19a. Informant's Name/Relations	ship <i>(Type,</i>	, Print)	19	b. Mailing	Address (Street	and Number or Rui	ral Route Numb	er, City	or Town, Sta	ate, Zip C	code)
		Paul Krese(fo	ather)				tone Dri		dbri	dge, V	′a. 2	2193
6		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 □Rem	noval from State	20b. Place cemete	of Dispos ery, crem	ition (Name of atory or other plac	ce)	Date	20c. L	ocation - Ci	ty or Towr	n, State
,		`4 □Donation 5 □ Other (S	Specify)				ematory	02/0	8/2005	Ale	xandı	ria, V	′a.
ODCe.		21. Signature of Funeral Service	Licensee	1	B			ss of Facility Old					
e 0			as	eco	SIN			Haven H			dria,		
		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complicat t only one o	tions that cause cause on each l	d the death. Do	not ente	r the mode of dyin	ig, such as cardiac	or respiratory a	rrest,		A	approximate nterval Betweer
		Indista Course (Elect		3	,		ę	•					Inset and Death
		Immediate Cause (Final disease or condition resulting in death)	a		11tiple	0	infur!	•				C	Inset and Death
al		disease or condition	(a		,	0	ę	•				C	Onset and Death
al er	er	disease or condition resulting in death)	b	Due to (or as	11tiple	e of):	ę	•				C	Onset and Deatl
al er	miner	disease or condition resulting in death)	b	Due to (or as	(/f/)/t	e of):	ę	•				C	Onset and Death
al er	Examiner	disease or condition	b	Due to (or as	(/f/)/t	e of):	ę	•				II C	Onset and Death
al er	Ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a b c d	Due to (or as	s a consequence	e of):	ę	•				C	Onset and Death
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State Registrar

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryla		artment of H tificate of			giene 2 (06933
	Physici	an	Decedent's Name (First, Middle, Last	st)				2. Date of De.	ath Day	3. Time of Death
	/Medic		Seibert Glenn	Kretzer				February		1005 0725 AM
	Examir	ier	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County	
			Washington County 5. Social Security Number 6. S		s. last birthday)	Hagerst If Under 1 Year	OWN If Under 24 Hrs.	8 Date of Bird	Washir	gton County
	Funeral Director			X3 M 2□F 81	Yrs.	Months Days	Hours Min.	Jan.	24,1924	9. Birthplace (State or Foreign Country) Pennsylvania
	D		Usual Residence of Decedent							
	anylar show	_	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8e-f	ecto	Maryland Washingt	con Co. Ha	gerstov					
	with th	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	ours after death with the Marylan ral', or Items 23e or 28e-f show Examiner must be notified at	Funeral Director	322 West Side Ave		118 13 1	21740		necify Yes or No	U.S.A.	- American Indian,
10	fler d	표	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No 1 0	142 4		tispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.
036	al', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give	943 to 9	I□Yes 2⊠No	Specify:		Specify:	White
5-0036	72 hc natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	lent's Usual Occup	pation	kina	16b. Kind of Bu	siness/Industry
2121	⊆ ₫	agu.	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)	9	77	33
	filed w Hygier other tl		12 17. Father's Name (First, Middle, Last)		Salesn	idi I	18. Mother's Nam	no /Eirst Middle		Cleaner Co.
anc	ould be filed Mental Hygi erked other etic event, I	Be	Richard J. Kretze				Beulah (•	Maiden Suntami	9)
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 la marked other than other traumatic event, I'm M	2	19a. Informant's Name/Relationship		19b. Mailin	a Address (Street	and Number or Ru		er. City or Town.	State. Zin Code)
Ma	D € Z ±		Rebecca A. Shephe	** *		Bryan Pla		cstown,		• -
ē,	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date		City or Town, State
E C	0 0		1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi				ry 2-19,	2005	Hagersto	own, Maryland
Baltimore	permit. Pag Department Importent: I any injury c		21. Signature of Formaral Service Licen	ISBB O	22	. Name and Addre	ess of Facility	vilac 7	Piowr I	Tuneral Home
m	8 9 1 6 8		1 Cancel	J. Toulou 1	V. 113	31 Easte	rn Blvd.	N. Hage	rstown,	MD 21742
	Physician /Medical Examiner physician and physician and physician sician	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	equence of):		ARCINO)	Interval Batween Onset and Death ONIE YIEAR
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	ding Ph h. After th funeral		27. Man r of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	ow injury occurre	ed
Division	Attending r death. ector: Alter by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	00/ 1		2 12 14
ΣĬ	or All after Direc in by	artif	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, stri cify)	eet, ractory, office		City or Tou		r or Rural Route Number.
	pital ours eral i		29a, Certifier 1 Certifying Ph	ysician: To the best of my kr	owledge death	occurred at the tir	me date and place	and due to the	cause/s) and man	nner as stated
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medicel Exert	niner: On the basis of examinand manner stated.	nation and/or inv	restigation, in my o	ppinion, death occur	rred at the time,	date and place, a	nd due to the cause(s)
	To the within Fo the complex c	Me	29b. Signature and title of certifier	ı		29c. Licens	e number		29d. Date signed	(Month, Day, Year)
			My Thull	MM PERGWA	1 PKY	SICIAN	Dea	14.250	FER	17 2005
			30 Name and address of person who	completed cause of death (Its	т 23а) (Туре,	Print)	1000		1 (-12)	117:5
SH	-16+1		KOBERT BRULL	1459 1010	DATAC	56. 14	AGERS"	TOWN	P9D :	41142
	Sta Registi	_	31. Date filed (Month Pay, Year)	32. Registrar's Sign	nature	perter				

			1 - For State Registrar	State of Maryla		artment of F		nd Mental Hy	giene Reg. No.	2005	0.6	03
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Š	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o		f Death	100	ounty of Death	_1_	
	Funeral	7.0	Citizens Nursin 5. Social Security Number 6. Sex		. last birthday)	Frede	If Under 2		rth	Frederi 9. Bjrthp	ck place (State o	or Foreign
	Director		220-42-5004	M 2XF 90	Yrs.	Months Days	Hours	Min. (Month, De Dec • 7	y, Year) 1, 191	4 Ma	ryland	1
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				1	0d. Inside Ci	ity Limits
	a-f eh	tor	Maryland Frederick	k V	Valkers	ville					1 XYes	2 🗆 No
	vith the	Dire	10e. Street and Number			10f. Zip Code			-	n of What Cour	•	
	leath v	Funeral Director	8320 Revelation A	Avenue 12. Was Decedent Ever in	U.S. 13.	217 Was Decedent of H		in? (Specify Yes or No., Puerto Rican, etc.)		ited Sta		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "naturel", or items 23a or 28a-f show item 27 is marked other than "naturel", but item Marical Examinations it is medical Examinations.	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2√ No	Specify:	, Puerto Rican, etc.)		Black, White, pecify: W	_{etc.} hite	
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ğ	and 2 shealth and n 27 io m		19a. Informant's Name/Relationship (Ty) Roy Franklin Smit	•				r o <i>r Aur</i> al Aoute <i>Numb</i> .ke Keymar			21757	
Jre,	es 1 and 20 Health fitem 27 r other tr	. 8	20a. Method of Disposition	20b.		osition (Name of matory or other place		Date		ation - City or To		
Baltimore,	Pages Iment of Iant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Re	sthaver	Mem Gar	dens 2			erick,		
Bai	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20028.		21. Signature of Funeral Service License	ae A		2. Name and Addre		Stauffer Walkersvi				
8760,	Physician Improved the principle of the	dical Examiner	shock, or heary failure. List only on Immediate Caus. Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a conse	quence of):	Carlie	o Vas c	ule Du	sérs		Interval Bett Onset and I	
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<u> </u>	ysicier is certif directo	To Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2[☐ ER/Outpatier	nt 3 DOA Oth	ar N	of Death (Check only sing Home 5 ☐ Resi		Other (Specifi		
on of	ding Ph h. After th funeral	tion: T	27. Manner of Seath 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. injur Wor	v at	28d. Describe			,	
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	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (sician: To the best of my kr ner: On the basis of examinand manner stated.)
	To th withir To th comp	Me	29b. Signature and title of certifier	1//		29c. Licens		7/	29d. Date	signed (Month,	Day, Year)	
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	, Q		30. Name and address of person with co	(/			eet I	rederick,	Marul	and 21	702	
5	Sta Regist		31. Date filed (Month, (13)B/e4) 6 2	005 32. Edistrar's Sign	nature	asali.	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year 9:00 A /Medical Albert V. Kilson 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Corsica Hills Nursing Home Centreville Queen Annes If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 1-26-1917 Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months 88 Director 213-24-0780 Maryland Usual Residence of Deceden death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23a or 28a-1 shov othar treumetic event, the Madical Examinar must be notified at Director 1 Yes 2 No Queen Annes Centreville Oueens Annes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Armstrong Ave. Funeral 21617 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer 8th Grade Farmhand 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of pe . Pagas 1 and 2 should be ment of Health and Menta tent: If item 27 is marked William Kilson Blanche Cheers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol W. Young/ niece 998 Barney Jenkins Road Felton DE 19943 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02-14-2005 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ŏ Vernon Church Cemetery tment injury Churchill, MD permit.
Departn
Importe
any inju 21. Signature of Juneral Service Licens Bennie Smith Funeral Home 717 W. Division Street, Dover, Delaware 19904 Junce Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Dehyloton 1975 /Medical Due to (or as a consequence of) **Examiner** Alzheiners Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cironic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 2 1 🗌 Yes 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: / in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DSIJ. LDS MD 8 30. Name and address f person who completed cause of death (Item 23a) (Type, Print) Dr. Frederick Delboy, 6602 Church Hill Rd., Chestertown, Maryland 21620 32 egistrar's Signatu EB 1 1 2005 State Registrar

		. 101	partment of Health and Ment ertificate of Death	al Hygiene 2005 06937
Physicia	an	1. Decedent's Name (First, Middle, Last) Frank A. Lewis	M	ate of Death 3. Time of Death onth Day Year
/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 24253 River Dr.	4b. City, Town, or Location of Death Chaptico	ruary 10, 2005 4:30am M 4c. County of Death St. Marys
Funeral Director		5. Social Security Number 578-26-3829 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday 81 Yrs. 1 Security Number 1 Security Number 1 Security Number 1 Security Number 1 Security Number 2 Security Number 1 S	y If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. Se I	ste of Birth Year 9. Birthplace (State or Foreign Country) Virginia
Balfilmore, Maryland 21215-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic evant, the Madical Examinar number notified at once.	To Be Completed by Funeral Director	10e. Street and Number 4211 Benning Rd. NE. 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last) Unknown 19a. Informant's Name/Relationship (Type, Print) Arlene D. Lewis/Spouse 12. Was Decedent Ever in U.S. Ammed Forces? 1 ★ Yes 2 □ No 1943 If Yes, Give Year or Dates: 1944 16a. Dec (Give life) If According to the print of the	ton, D.C. 10f. Zip Code 20019 . Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 □ Yes 2 ₺ No Specify: edent's Usual Occupation e kind of work done during most of working DO NOT use retired) ctronic Technician 18. Mother's Name (First Carrie Moling Address (Street and Number or Rural Rout Benning Rd. NE; Wash costion (Name of ematory or other place) National Cem. Feb. 15, 2	Specify: Black 16b. Kind of Business/Industry Federal Government t, Middle, Maiden Sumame) ten te Number, City or Town, State, Zip Code) ington, DC. 20019 20c. Location - City or Town, State
death certificate be executed Wedical e attending physician and ior use as the burial-transit	cal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiac or resp	Marlboro Pike stville; MD 20747 Approximate Interval Between Onset and Death Weeks Umovary lisease Syears
LO. BOX 68 It the death certifica by the attending ph tached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
S, Festhal	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 2	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ PTObably 4 ☐ Unknown
The law The law ate has b	Completed			4a. Was an autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
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UIVISION spital or Attending ours after death. eral Diractor: After filled in by the fune	Certificati	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		ocation (Street and Number or Rural Route Number, ity or Town, State)
Lothe Hospital within 24 hours a Totha Funeral I completely filled	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deadless of examination and/or and manner stated.	ath occurred at the time, date and place, and dunivestigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
To t withi com	Σ	29b. Signature and title of certifier MD	29c. License number D 005450 8	29d. Date signed (Month, Day, Year) 2 111 2005
(5)		30. Name and address of person who completed cause of death (Item 23a) (Type John Chuke, M.D. 6104 Old Branch A	o.Print) Ve., Temple Hills, MD.	. 20748
Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6 2005	d)	

Dhuaic	25	State Registrar 1. Decedent's Name (First, Middle, Las	t)	Cer	tificate of l	Death	2. Date of Dea	Reg. No.	CUL	0 6 9 3
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Examir	ier	Fort Washington H	ospital		Ft. Wa	Location of Death		Pri	inty of Death	
uneral irector		5. Social Security Number 6. Sec. 111-13-2368	7. Age (In yrs. la	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay Dec • 4,	1919	9. Birthi Coul Pan	place (State or F ntry) ama
28a-f show	ector	10a. State 10b. County Maryland Prince G 10e. Street and Number		Town or Loc	ngton					10d. Inside City
3a or	JO I	6800 St. Ignatius	Drive		10f. Zip Code 2074	4			of What Could	•
ral, or Items;	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates:	lf.	Vas Decedent of Hi Yes, specify Cuba X Yes 2□ No		pecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	can Indian,
han "natu e Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give A life. D	ent's Usual Occupa kind of work done of OO NOT use retired,	ation luring most of work)	king		f Business/In	dustry
7 is marked other than "	To Be Co	8th 17. Father's Name (First, Middle, Last) James Martin		House	wife	18. Mother's Nam		Domes		
Important: if item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, if a Madical Examinar must be notified at once.	99.	19a. Informant's Name/Relationship (T) Anna Smallwood-Rob 20a. Method of Disposition 1	inson/Daughter 20b. Pla Cer Cer	6800 ice of Dispos metery, crem	ition (Name of atory or other place	tius Dr.	Ft. Was	h.,Maı 20c. Locatio	yland on - City or To	20744 own, State
Importan any injur once.		21. Signature of Funeral Service Licens		A1	ion Cem. Name and Addres exander 3 38 Marlbo	\$ 2/19 S. Pope I Oro Pike	Funeral 1	Homes	on, Man	
sician edical iminer		23a. Part1. Effer the disease, or compishock, of heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	^	embol		g, such as cardiac	or respiratory arr	est,		Approximate Interval Betwee Onset and Dea
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cate has been s page 2 should	Completed by						24a. Was ar autops perform 1 Yes 2	y .	prior to con death?	osy findings ava npletion of cause 2 No
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al Director: ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (Str City or Town		nber or Rural	Route Number,
he Funer pletely fill	edical	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the time stigation, in my opi	e, date and place, a nion, death occurr	and due to the ca ed at the time, da	use(s) and i	manner as sta e, and due to	ated. the cause(s)
0 0	Σ	29b. Signature and title of certifier	٧-		29c. License		i i		ned (Month, E	
7		ween ! can	4 7		933	Rond, Fo		14>4x	m 14	, Zeus

, hysici	ian	1. Decedent's Name (First, Middle, Las		rmatrono	LaCour		2. Date of Month	Da		
/Medi			Beatrice A	rmstrong		and another of F	Febru		22, 200 County of De	
Examir	ner	4a. Facility Name (If not institution, give Fort Washington M		or		, or Location of E Tashingto				
uneral		5. Social Security Number 6. Se		n yrs. last birthday	If Under 1 Yea	ar If Under 24				eorge's inthplace (State or Foreig
rector		578-54-2675	□M 2 X F	66 Yrs.	Months Day	s Hours	Min. 8. Date of I (Month, Decem	ber 3	0, Wa	shington,D.
3		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or L	ocation					10d. Inside City Limits
f sho	ō		Georges		Washing	gton				¥XYes 2 □ No
r than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at	Director	10e. Street and Number			10f. Zip Code)		10g. Ci	tizen of What (Country?
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ems er m	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of	f Hispanic Origin uban, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An Black, Wh	nerican Indian, nite, etc.
t or the	by Fu	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X N				Specify: B	lack
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other than rent, the M	Completed		4 plus years	s Staf	f Superv	visor		Con	sultan	ts
	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd	lle, Maider	n Sumame)	
	ပို		rmstrong, J			Vivi			loss	
3 P		19a. Informant's Name/Relationship (7					or Rural Route Nur	-		
em 27 ther tr		George Joseph Lac		20b. Place of Disp	osition (Name of	1	Date	1	ocation - City of	1and 20748 or Town, State
		1 Burial 2 XCremation 3	Removal from State	cemetery, cre	ematory or other p	Place) Feb	.25,2005			e,Maryland
Important: If any injury or once.		* 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Safyice Licen	- 1- f		ake Crem					
any one		Xander h	R Phylad		R. N. H 600 Ken	Horton C	ompany Mo	ortic	ians,] hingtor	Inc. n,D.C. 2001
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Funeral Director			ns Davs Hours Min.	Date of Birth (Month, Day, Yea arch 19,1	Wicomico 9. Birthplace (State or Foreign Country) 946 Maryland
the Maryland 28a-f show	rector	10a. State 10b. County 10c. City, Town or Location Maryland Wicomico Pittsville 10e. Street and Number 10f.	Zip Code	100.0	10d. Inside City Limits 1 ☐ Yes 2 No Citizen of What Country?
if e, INIGITY IGHT A FIZED-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. if the All and Mental Hygiene. other traumatic event. It is Medical Examinat must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. If Yes, s	21850 cedent of Hispanic Origin? (Specifi pecify Cuban, Mexican, Puerto Ric	U	SA 14. Race - American Indian, Black, White, etc. Specify: White
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It. Pages 1 and 2 si rtment of Health an rtant: If item 27 is n njury or other traur		Linda Lane (wife) 34680 War 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Accemetery, crematory of Community Community)	r other place)	sville, Ma	aryland 21850 Location - City or Town, State
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	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I	26. Place of Death (C.	The state of the s	
Attending Ph ir death. ector: After th by the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Place of Injury - At home, farm, street, factor building, etc. (Specify)	28c. Injury at Work? 1 Yes 2 No	. Describe how inju	iry occurred and Number or Rural Route Number.
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurre and manner stated. Certifying Physician: To the best of my knowledge, death occurre and manner stated.	on, in my opinion, death occurred a	at the time, date an	d place, and due to the cause(s)
To with	2	Cathama R. Homen	9c. License number D 4 50 U 3	2	te signed (Month, Day, Year)
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	Physic /Med		Decedent's Name (First, Middle, Las HAZEI		D				Date of Death Month eb 1	Day	0°05	3. Time of 11:5	
	Exami		4a. Facility Name (If not institution, give Holy Cross F	Hospital		1	r Spr	ing		4c. County		ry	
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yea Months Day		Min. D	Date of Birth (Month, Day ec 10	,1924	9. Birthpl Jama	ace (State or try), alca	r Foreign
	vith the Maryland t or 28a-f show	Director	10a. State 10b. County Md Montgon 10e. Street and Number		Silv	er Spr			10	g. Citizen of W		0d. Inside Cit 1 MgYes try?	•
9036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Ezana inchinat be notified at	by Funeral	531 Randolph I 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	Rd , #330A 12. Was Decedent Ever in U Armed Forces? 1	1	20904 Was Decedent of f Yes, specify Cu	f Hispanic Orig uban, Mexican, o Specify:	gin? (Specify Puerto Rica	Yes or No- an, etc.)		- America k, White, e	tc.	
Baltimore, Maryland 21215-0036	e filed within 72 hours at Hygiene. other than "natural", vent, the Medical Exa	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 6th Grade 17. Father's Name (First, Middle, Last)	ucation de <i>completed)</i> College (1-4or 5+)	life. L	lent's Usual Occi kind of work don OO NOT use retii ering	upation le during most red) Assisi	of working tant	1.	Food Akin	siness/Indi Ser -Gumi	vice	
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	To the within to the comp	Me	29b. Signature and title of certifier One of the signature and address of person who co	MD.	1 23a) (Type, P	rint)	560			Date signed (as	- 0910	, Mc
	Sta Registr		31. Date filed (Month, Day, Year) FFR 1 5 200	32 Registrar's Signal		1500		- GIE	ii Ku,	D T T V 6			, 110

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** 2005 FEBRUARY 10, 3:30 **JOSEPH** LEBLANG W. /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY 1801 E. JEFFERSON STREET 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Nov. 28, 19 #204 ROCKVILLE 9. Birthplace (State or Foreign Country) 1909 NEW YORK 5. Social Security Number 6. Sex **Funeral** 11X1M 2□ F Director 091-01-0833 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo MARYLAND MONTGOMERY ROCKVILLE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with ö or Items 23a JEFFERSON ST., #204 20852 U.S.A. death v 1801 E. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 6 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, it is wholf at Exemina 100ce. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNASCERTAINABLE ANNIE LEBLANG NATHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8817 HARNESS TRAIL, POTOMAC, MD 20854 MATTY J. GLADSTONE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) 02/14/2005 FALLS CHURCH, VIRGINIA NATIONAL CREMATORY 21. Signature of Funeral Service License DANZANSKY-SÖLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Sonald C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final a ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): sician Box 68760 Physician/Medical nding physics use as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ANEMIA Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RECTAL CANCER certificate Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident al or Attancs after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 🗍 Homicide Hospital within 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Della 2005 D0057884 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 E. JEFFERSON ST., ROCKVILLE, MARYLAND 20852 DAMIEN J. DOYLE, M.D., egistrar's Signature 31. Date filed (N 1 5 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MARY LONGO 02 14 2005 10:25 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SARA, MARGARET & MOLLIES PLACE SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09-19-1902 Birthplace (State or Foreign Country) **Funeral** 1 □ M 27 F Months Days Hours 181-16-2105 Director 102 WASHINGTON, PA. Usual Residence of Decedent with the Maryland 10a, State 10b. County show 10c. City. Town or Location 10d. Inside City Limits THE 23s or 28s-f show Y Yes 2 □ No Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9288 HICKORY MILL ROAD 21804 death Funeral USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give △ or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: 3 Widowed 4 □ Divorced WHITE Year or Dates: "naturel" r then "nature Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME other Department of Health and Mental Hyg Important: If item 27 is marked othe eny injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be JOSEPH BRUNO FRANCESCA DURANTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK LONGO - SON 4380 EXETER DRIVE, LONGBOAT KEY, FLORIDA 34228 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Important: I *4 □Donation 5 □ Other (Specify) GLENDALE CEMETERY 02-16-2005 BLOOMFIELD, NEW JERSEY permit. 21. Signature of Juneral Service Licenses 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Pgrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** HYPOXIA /Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE HEART ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Be Completed page 2 should been ACEMAKER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed certificate 1 Yes 2 No rector. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ASST. 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA luneral dir LIVING 27. Manne eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Vatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital pelili 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) ţ, 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0060515 completed cause of death (Item 23a) (Type, Print) M. IHIMM ARAYA SHIRE DR SHLISBURY 31. Date filed (Month State Registrar

			1 - For State Registrar	State of Ma	ryland /	-	rtment tificate			ınd Me		jiene	7 (7	0.6011
	Physici	an	Decedent's Name (First, Middle, Last) THOMAS MATTHEW I	FONARD						2	Date of Dea Month FEBRUA	th Day	J) - Year 005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s 24110 KINNAIRDS P	treet and number)			WO	RTON			FEDRUE	4c. County of	of Death	
	Funeral Director		5. Social Security Number 6. Sex 174-48-7196 Usual Residence of Decedent	M STE	(In yrs. last b	rirthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. A	. Date of Birth (Month, Day ugust	3, 1957	9. Birthp Cour OH	place (State or Foreign htry)
	with the Maryland a or 28a-f show	tor	10a. State 10b. County MD Kent		10c. City, Tov Wor	wn or Loc	ation						1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	h with the	al Director	10e. Street and Number 24110 Kinnairds	Point Dri	ve		10f. Zip				1	0g. Citizen of W	hat Cour	ntry?
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural, or items 23a or 28a-f show of other then "natural, or items 23a or 28a-f show avent, the Medical Examinational Local Action of the Action of the Medical Examination of the M	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	I2. Was Decedent Ev Armed Forces? 1 □ Yes 2 XNo If Yes, Give Year or Dates:		lf lf	Vas Deced Yes, spec	rfy Cubar	spanic Orig n, Mexican, Specify:	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)		, White,	
Maryland 21215-0036	d within 72 ho giene. er then "natu	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give I	O NOT us	k done d	urina most	of working		16b. Kind of Bus		dustry
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e, Mar	as 1 and 2 should of Health and Mer litem 27 Is marker other traumatic		19a. Informant's Name/Relationship (Ty) Barbara Leonard/Wi 20a. Method of Disposition			4110	Kinr	nairo			r., Wo:	rton, MI 20c. Location - 0	216	578
Baltimore,	Page nent o ant: If ary or		1 ☐ Burial 2 ☒ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		St. P	au1'	atory or ot S	her place		eb.12		Chester	•	
■ Ba	Departi Departi Imports any inju		23a. Part 1. Enter the disease, or compli	Yeler	to death. De	F	e11ov 30 Sp	vs, l	lelfer Road	nbein , Ches			ra1 21620	Home, P.A.
	Physician /Medical Examiner		shock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line Contact Due to (or as a							espiratory arr	esi,		Interval Between Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):								
8760,	icate be executed physician and s the burial-transit	dical	resulting in death) Last	Due to (or as a	consequence	of):								
.O. Box 6	at the death certificate be executed by the attending physician and lached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal deat		Ectopic pre Other <i>(spe</i>					23d. Date Mon		ory Day Year
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Division o	or Attending ifter death. Director: After in by the fune	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day) 2/7/05 28e. Place of Injur building, etc.	y - At home, f		М	office	at ? es 2XN Lem	lo §	Location (St City or Town	ow injury occurre A Share reet and Number State) 2 9/11 W L	t S	I foute Number.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ledical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Examin	ician: To the best of er: On the basis of e and manner state	xamination a	je, death nd/or inve	occurred a estigation,	it the time	e, date and inion, death	place, and	due to the ca	ause(s) and man	ner as st	ated.
)	To th withir To th comp	Me	29b. Signature and title of certifier	ah Al	2~		29c.	License				9d. Date signed FEBRUARY		
			30. Name and address of person who co 2481ULLA	mpleted cause of dea		(Type, P		Penr	ı Stre	eet Ba	altimo	re, Mary	land	1 21201
:::	Sta Registr		31. Date filed (Month, Day, Year) 7 FEB 10 20	05 32. Registrar	's Signature			,						

State of Maryland / Department of Health and Mental Hygiene 2000

			(Certificate	of Death	R	eg. No.	103	0694
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/Medical Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or I	ocation of Death	4c. County	of Death	
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v ≈ 5 0 m	JOSEPH	SZABO				ILONA	PROB	ASZKA	
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12 a 1	MARIANNE SLOAN	/DAUGHTER	60	18 HAVEN	ER HOUSE WA	Y CENTR	EVILLE.	VA.2	0120
# # E E	20a. Method of Disposition	DAUGHILK	20b. Place of	Disposition (Name	of	Date	20c. Location -		
Sec 10	1 █ Burial 2 ☐ Cremation 3 ☐			r, crematory or oth		2-11-05	CTIVED	сррт	NG, MD.
rtant reart	4 Donation 5 Other (Specify		GATE U		CEMETERY Addrass of Facility	2-11-05	PILACK	SPKI	NG, FID.
permit. Pag Department Important: any Injury pnce.	21. Signature of Funeral Sarvice Long	nhersa	~ M∩∩∩01	CHAMBER	S FUNERAL H EVELAND AVE				
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rs after death. Is after death. Is Director: After to led in by the funers Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury building, atc.	/ - At homa, fa (Specify)	m, straat, factory,	office	28f. Location (S City or Tox	Street and Numb m, State)	ber or Rural	Route Number,
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State

Registrar

FEB 1 4 2005

			1 - For State Registra WEND#19aperINF.	State of Maryla		artment of H			jiene	00016
			Decedent's Name (First, Middle, Last)		,			2. Date of Dea	th	3. Time of Death
н	Physici	an	ANDREAS MAKRIS					February	3, 2005 Year	1:15 P M
	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	_
	Examin	er	11204 Oakleaf Dri			Silver S	Spring		Montgome	erv
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	tholace (State or Foreign
	Director		497-36-0530 ¹ X	M 2□F 74	Yrs.	Months Days	Hours Min.	March 7	1930 Salc	onika Greece
	P .		Usual Residence of Decedent							
	show	٠.	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits ty∑ Yes 2 □ No
	86-1	Director	MD Montgome	ry Si	lver Sp					71
	with th	Dir	10e. Street and Number			10f. Zip Code 20901	1		Og. Citizen of What Co United Sta	•
	s 23	Funeral I	11204 Oakleaf Dri	12. Was Decedent Ever in	10 12			nooifu Voo or No	14. Race - Ame	
	item Item	nu.	11. Marital Status 1 Never Married Married	Armed Forces? 1 ☐ Yes 2 X No		Was Decedent of H f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
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Maryland 21215-0036	2 shc and is m		19a. Informant's Name/Relationship (Ty, Lubbe	pe, Print)	1				, City or Town, State,	
2	and lealth m 27		Margaret Labbe Mak			oaklear sition (Name of		Date Date	oring, MD 2	
Baltimore,	8 5 5 5 D		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	lemoval from State	cemetery, crer	natory or other plac	ce)	8	20c. Location - City or	
Ħ	t. Pa rtmen rtent: rjury		'4 □ Donation '5 □ Other (Specify)			1n Cremat			Brentwood,	
Bal	permit. Pages 1 and 2 should be Department of Health and Mental Importent; if Item 27 is marked can vinjury or other traumatic evonce.		21. Signature of Funeral Service License	mall						Home, Inc.
			23a. Part 1. Enter the disease, or compli	cations that caused the dea						Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	~		3, 00011 40 0410140	o		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conse)					DME
	Examiner			Due to (or as a conse	querice or,					
	-	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
	cuted	Examine	Causa (Disease or injury that initiated events							
oʻ	The law requires that the death certificate be executed the subset signed by the attending physician and oage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):					
8760,	ate be nysici he bu	Physician/Medical		1.						
9	intification of a section of the sec	Med	IF FEMALE:							
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe	al death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	the a	sici	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5∟	Other (specify)				,
<u>o</u> .	that the died by the detached		Part II. Other significant conditions con	ntributing to death but noting	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	pacco use contribute to	the cause of death?
Vital Records,	signe d be	l by	Diabeles	me 1/1 to	C	, , , , , , , , , , , ,		1 □ Y	es 2⊉No 3□Pr	robably 4 Unknown
Ö	w requii been s should	etec	16. 6/					24a. Was a	n 24h Wara au	utopsy findings available
36	has has	ompieted	10/10/16/9	CD 1 015				autops	y prior to	completion of cause of
a		e Co	25. Was case referred to medical				00 Bloom of Book			2 No
		o Be	examiner?	lospital:	☐ ER/Outpatien	t 3 DOA Othe	26. Place of Deal er: 4 ☐ Nursing Ho	2.2	ence 6 □Other (Spe	cuts)
of	Phys or this eral di	 	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	y at	-	ow injury occurred	sily)
lon	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1 □ `	Yes 2□No			
Division	Atternation of the part of the	iffic	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (St City or Town	reet and Number or Run. State)	ural Route Number,
	tal or	Certification;		Bananig, etc. (epoc						
	To the Hospital or Attending Phwithin 24 hours efter death. To the Funerel Director: After the completely filled in by the funeral	edicai		sician: To the best of my kr						
	the H hin 24 the F nplete	Medi	one)	and manner stated.						
1	tivit To To		29b. Signature and title of pertifier	1		29c. License	/	2	9d. Date signed (Month	_
7	12		35000	Kermo Dr				00	Leb 11	2007
			30. Name and address of person who so	mpleted cause of death (Ite	mi zoa) (Type,	3/1/0-	Cy 10 in a	na m	カラクラ	101
	Sta	te	31. Date filed (Month, Day, Year) EB 1 4 20	32. Pegistrar's Sign	ature	3. Vor	pir	1		
	Registr		reb 1 4 20	US A MARIE	15 Bb	sec.				

		1 - For State Registrar	State of Maryl		artment of H			ene 1. N2. () () 5	06947
0		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physic /Med		LONNIE Y. MILLER					Month FEBRUARY	8, 2005	12:45 P M
Exami		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Dea	ath	4c. County of Deat	h
		CASEY HOUSE			ROCKVILI			MONTGOMER	
Funeral		5. Social Security Number 6. Sex	M OFIE	<i>rrs. l</i> ast birthday) 55 Yrs.	If Under 1 Year Months Days	Hours Mir	n. (Month, Day, Y	rear) Co	hplace (State or Foreign
Director		Usual Residence of Decedent		55 Yrs.			DEC. 22,	1949 NEW	YORK
yland now		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
Mar Mar	ţo	MARYLAND MONTGOMER	Y GA	ITHERSBU	TRG				1∭XYes 2⊡No
th the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
23e		340 MARKET STREET	E. #171		20878		ַ ַ ַ ַ	S.A.	
er deg	Funeral	The transfer States	12. Was Decedent Ever i Amed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (n, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, White	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 □ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X ☐ No	Specify:		Specify:	WHITE
2 hou		15. Decedent's Educ	cation		dent's Usual Occupa		16	b. Kind of Business/	
hin 72 n "n	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of wi l)	orking		•
d with	Completed	12		MANIC	URIST		N	AILS	
be filed within 72 hours after death with the Maryland Ital Hygiene. d other then "natural", or items 23e or 28a-f show event. I'm Medical Examiting:	Be (17. Father's Name (First, Middle, Last)					ame (First, Middle, Ma	iden Sumame)	
should Ind Meni	မ		MILLER	-		SHEILA		LEPCOFKER	
12 sh h and 7 is m		19a. Informant's Name/Relationship (Type					Ru <i>ral Route Number, C</i>		(ip Code)
1 and Health em 27		JESSICA L. LILIENF 20a. Method of Disposition		ER 965 M b. Place of Dispo		ET GAIT		MD 20878 c. Location - City or	Town State
Pages nent of I	1	1 Burial 2 □ Cremation 3 □R	emoval from State	cemetery, crei	natory or other plac		1	CITY 1	
		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			EM. GARDE . Name and Addres		10/2005 OL		
permit. Departr Importe any inju		Donald C. X	Stattleme	ees II	NZANSKY-C 70 ROCKVI	OLDBERG LLE PIK	MEMORIAL E, ROCKVIL	CHAPELS	INC 852
Physician /Medical Examiner	ner	if any, leading to immediate	HEPATIC FA. Due to (or as a con METASTATIC Due to (or as a con	LURE sequence of): NEOPLAS			ac or respiratory arrest	1	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-		TIC BREAS	T CANCE	R		
the death certific y the attending p iched for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
w requires that the del been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause give	on in Part I.		cco use contribute to 2₭ No 3☐ Pro	the cause of death?
sicien: The law requi certificate has been frector, page 2 should	Completed						24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
icien: ertific ector,	Be (25. Was case referred to medical examiner?	acostal:				eath (Check only one)		
Physi this o	P	1 ☐ Yes 2 🗶 No		ER/Outpatien		4 Nursing	Home 5 Residenc		ify)HOSPICE
ling F After funer	ion	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work	at :? (es 2 □ No	28d. Describe how	injury occurred	
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)		195 Z 🗆 NO	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
he Hospita n 24 hours he Funera pletely fille	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tim restigation, in my op	e, date and plac sinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the comp	Σ	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	Day, Year)
2		4 Clil			114	121	5	22/08	105
		30. Name and ad ress of person who con			•				70
		CHARLES HARRISON, N	1.D., 6001 M		R MILL RO	AD, ROCE	KVILLE, MD	20855	
Sta	ate	31. Date liled (Month, Day, Year)	15	K L	ales				

			For State Registrar	State of N	Maryland / Dep Ce	ertificate of			iene 19. No. 2005	0.601.6
	Physici /Medic		1. Decedent's Name (First, Middle Gabriela Mari	a Mata				2. Date of Death Month February	Day Year 7 10, 2005	3. Time of Beath?
	Examir	ner	4a. Facility Name (If not institution Montgomery Ho	spice-Casey	House		r Location of Dea		4c. County of Death Montgom	
	Funeral Director		5. Social Security Number 219-96-1186 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 ☑ F	Age (In yrs. last birthda) Yrs.	Months Days	Hours Min		Year) Cou	place (State or Foreign ntry) 1and
	Maryland e-f show	ctor	10a. State 10b. County Maryland Montg	omerv	Germant					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any Injury or other treumatic event, the Medical Example must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 18927 Ebbtide 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Deceden (Specify only highestellar) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Santos Victor 19a. Informant's Name/Relations Carlos V. Mat. 20a. Method of Disposition 1 Burial 2 Termation 4 Donation 5 Other (S 21. Signature of Funeral Service	Circle 12. Was Deceder Armed Force: 1 Yes 20 If Yes Give Year or Dates It's Education It's Education College (1-40 2 Last) Acuna hip (Type, Print) Husbar 3 Removal from States	nt Ever in U.S. 13 s? XNo s: 16a. Dec (Givenities) if the life state of the life sta	Was Decedent of H If Yes, specify Cubz 1 Yes 2 No edent's Usual Occup e kind of work done of DO NOT use retired 2 Occup ling Address (Street 2 T Ebbtide consition (Name of smalory or other plactitan irematory 22 Name and Addres 'rancis J. 100 Univer	Specify: sation during most of we diring most of we diring most of we diring most of we learned Number or Re Carme and Number or Re Circle Selection Selec	Specify Yes or No- nto Rican, etc.) orking ame (First, Middle, No. 21a I. Lav lural Route Number, Date 2 14,2005 S Funeral rd., W., Sil	Medical faiden Sumame) viano City or Town, State, Zij www., Marylan Oc. Location - City or To lexandria, Home, Inc. ver Spring	can Indian, etc. hite dustry cocode) d 20874 own, State
Box 68760,	death certificate be executed way a strength of the attending physician and a strength of for use as the burial-transit	Physician/Medical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	a. Brain Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom	Tumor Gliol as a consequence of): as a consequence of): as a consequence of): as a consequence of):	□ Ectopic pregnancy		me	23d. Date of deliv Month	Interval Between Onset and Death 3 years ery Day Year
rds, P.O.	es that the gned by th be detache	by	9 Unknown Part II. Other significant condition	9□ Unknown		underlying cause giv	en in Part I.		acco use contribute to t	he cause of death?
Vital Records,	The law ate has b page 2 si	Completed							prior to co death? No 1 Yes	opsy findings available impletion of cause of 2 No
Division of Vit	tending Physici leath. tor: After this cer the funeral direc	Certification: To Be	25. Was case referred to medica examiner? 1	Hospital: 1 Inpa 28a. Date of Ir (Month, E) 28e. Place of I		of 28c. Injun Wor M 1	er: 4 🗌 Nursing	28d. Describe ho	nce 6 Other (Special w injury occurred	
۵	Hospital of thours af Funeret Dely filled in	edical Cer	29a. Certifier 1 X Certifyir (Check only one) 2 Medical	g Physician: To the be: Examiner: On the basis and manner	of examination and/or	oth occurred at the tin	me, date and place	e, and due to the ca curred at the time, da	use(s) and manner as s te and place, and due to	stated. o the cause(s)
)	To the within 2 Complete	Med	29b. Signature and title of certifie	P. Ze	be n	р 03			bruary 11,	
	Sta Regist		30. Name and address of person Eugene P. Libre 31. Date filed (Month, Day, Year) FEB 1	e. M.D. 10		ticut Ave	nue Ken	usington,M	aryland 20)895

Please Type or Print in Black Indelible Ink.	Enguro All Copies Are Legible
riease Type of Fillit in black indelible lik.	Elisure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11,2005 12:36 A M **Physician** Franklin Mattison February Quincy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors' Hospital P.G. Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 (Month Day, Year) 1 1 1 5 1 1937 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Days Hours 67 Washington DC Yrs. Director 578-50-9671 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. nent of Health and Mental Hygiene. nnt: If Item 27 is marked othar then "natural", or Itams 23a or 28a-1 show or other traumatic avant, the Mudical Examiner must be nutified at 1 Yes 2 No Director P.G. MD Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7803 Old Ardwick Ardmore Road 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Xes 2 No
If Yes, Give
Year of Dates: 56 -62 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12th Truck Driver U. S. Postal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy Jefferson Preston Mattison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7803 Old Ardwick Ardmore Road; Hyattsville, MD 20784 Norma S. Mattison - Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Md. Veteran Cem Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/18/2005 permit. Page Department of Important: If any injury or Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Freeman Funeral Services sending P. O. Box 416; Suitland, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE SEPTIC SHOCK **Physician** /Medical Due to (or as a consequence of) Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760 CARCINIOMA OF TONSIL + TONGUE Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by INTRAVASCULAY COAGULOPATIA 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No GASTROENTERAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No autopsy THYROLD 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 27. Magner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attanding within 24 hours after death.
To the Funaral Diractor: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21200 cause of death (Item 23a) (Type, Print) HANOVER PKKLY

Registrar DHMH 17 Rev 1/2001

State

31. Date filed

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Day Year **Physician FEBRUARY** 11,2005 1050 A PRISCILLA W. MEYER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOSPICE-CASEY HOUSE MONTGOMERY ROCKVILLE If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex Days Min. Hours 1 ☐ M 2 🗓 F Months Director APR. 21, 1925 FLORIDA 265-28-8764 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🛛 No MARYLAND MONTGOMERY SILVER SPRING Directo the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4106 WELLER ROAD 20906 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: à 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HEALTH CARE and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fili.
Department of Health and Mental Hy
Important: If Item 27 Is marked oth
any injury or gither traumatic event 17. Father's Name (First, Middle, Last) Be HENRY MURPHREE WHITE ပ IDA MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON 4106 WELLER ROAD SILVER SPRING, MARYLAND 20906 GLENN L. MEYER 20b. Place of Disposition (Name of cometery, crematory or other place)
GATE OF HEAVEN 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY FEB. 15, 2005 SILVER SPRING, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FRANCIS J. COLLINS FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 UNIVERSITY BLVD., W., SILVER SPRING, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Subarachnoi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ţō in the past 12 months? 1 ☐ Yes 2 XNo Day 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 21 No 1 Yes Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 □ No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) Ot, 12, 2004 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 3:30 а.м. or Attending 5 Pending investigation 1 Natural fal death. 1 Yes 2 Accident after death 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Toyyn, State) 28e. Place of Injury - At home, farm, street, factory, office j building, etc. (Specify) determined 4 Homicide Weller Rd, Silven Spring, MD 4106 nome thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier tatucia Name and address of person who completed cause of death (Item 23a) (Type, Pri LOMS icia 31. Date filed (Month, Day, Year) Registrar's Signature State 1 4 2005 Registrar

					artment of Health and	•	•
			1 State		rtificate of Death		ZIIIIS ACOF
			Registrar 1. Decedent's Name (First, Middle, Last)		imouto or Boath	2. Date of Deatl	
	Physici /Medic			ills		Month February	Day Year
4	Examir		4a. Fecility Name (If not institution, give street and r	iumber)	4b. City, Town, or Location of Dea	th	4c. County of Death
		Н	Wicomico Nursing Home	T 7 4 - 1/2	Salisbury If Under 1 Year If Under 24 Hrs	0.0	Wicomico
cs.	Funeral Director		5. Social Security Number 215-20-1234 Usual Residence of Decedent	7. Age (In yrs. last birthday) 79 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country) 7, 1926 Pennsylvania
	land low		10a. State 10b. County	10c. City, Town or Lo	ecation		10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinating Injury and page.	ctor	Maryland Wicomico	Salisbury	7		1ÆYes 2□No
	or 28	Director	10e. Street and Number		10f. Zip Code	10	Og. Citizen of What Country?
	ath w	<u>a</u>	1110 Healthway Drive		21801		USA
	er de	n n	Armed	Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	 Race - American Indian, Black, White, etc.
36	rs afte	by Funeral	1 ☐ Never Married 2 【 Married 1 【 Yes, (3 ☐ Widowed 4 ☐ Divorced Year or	a 2□No Army	1 ☐ Yes 2 No Specify:		Specify:
o o	hou	edk	15. Decedent's Education		dent's Usual Occupation	1	White 16b. Kind of Business/Industry
715	nin 72 In "na	Completed	(Specify only highest grade completed	d) (Give	kind of work done during most of wo DO NOT use retired)	orking	,
21	giene grene er the	Com	12		ervice Technician		Storer Cable Comapny
D D	al Hy	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, M	faiden Sumame)
yla	Men Men arke	၉	William Shockley	Mills	Bertie		Davis
Maryland 21215-0036	12 sh h and 7 is m traum	i	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or R		
	1 and Healtl em 27 ther 1		Cynthia Louise Hayman (20a. Method of Disposition	Caughter) 3625 20b. Place of Dispo		7	s, Georgia 30041
Š	nt of I		1 XBurial 2 ☐ Cremation 3 ☐ Removal from	m State cemetery, crer	natory or other place)		
Baltimore,	artme ortani injury		* 4 □ Donation 5 □ Other (Specify) ZT. Signature of Funeral Service Licensee	Springhill 1	Memory Gardens Febru	ary 17,2005	Hebron, Maryland
Ba	Depar Depar Impor any ir	1	1. 12/10		00110way Funeral 001 Snow Hill Roa		essional Association
Ė			23a, Pert1. Enter the disease, or complications tha	t caused the death. Do not ent			st. Approximate
,	Physician		shock, or heart failure. List only one cause or Immediate Cause (Final	LUME In	TARIVE		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	o (or as e consequence of):	CANCER.		
×	Examiner		F4	PHAGEAL	CANCER.		
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):			
	acute ind trans	Examiner	that initiated events c.				
760,	be executed icien and burial-transit		Due t	o (or as a consequence of):			IV.
6876	ficate be executed g physicien and is the burial-transit	dical	d				
× 6	The law requires that the death certificate ite has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23c. If yes, of	outcome of pregnancy			23d. Date of delivery
Вох	atten for u	clan	in the past 12 months?	birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
<u>о</u> .	that the do	hysi	1 Yes 2 No 9 Unk				
ŭ,	s that ned t	by P	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Division of Vital Records,	w requires to been signer should be controlled.	ed t	HNXIETY			1 ☐ Yes	s 2 □ No 3 □ Probably 4 □ onknown
000	aw re	Completed	BENIGN PROSTATIC	HYPEKTROP	°HY	24a. Was an autopsy	
œ —	The la ate ha page	Com	CHRANIC OBSTRUCTIVE	PHIMONARY	DISEASE	perform	ed? death?
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical		26. Place of Qe	ath (Check only one	
<u></u>	Physic this or	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2 ER/Outpatien		7	nce 6 Other (Specify)
Ü.	Attending Physician: ir death. ector: After this certifice by the funeral director, i	lon:	1 ☑Natural 5 ☐ Pending (Mc	e of Injury 28b. Time of Injury Injury	Work?	28d. Describe how	w injury occurred
<u>s</u>	death death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	ce of Injury - At home, farm, str	M 1 Yes 2 No	28f Location (Stre	eet and Number or Rural Route Number.
<u>></u>	after deall Director: I in by the	Certification:		Iding, etc. (Specify)	eet, ractory, onice	City or Town,	
_	Hospital 24 hours 2 Funaral I	a C	29a. Certifier 1 Certifying Physicien: To t	he best of my knowledge, death	n occurred at the time, date and place	e, and due to the car	use(s) and manner as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the tuneral director, page	edical	(Check only 2 Medical Exeminer: On the	basis of examination and/or in anner stated.	vestigation, in my opinion, death occ	urred at the time, da	te and place, and due to the cause(s)
	To the Hi within 24 To the Fi complete	M	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Dey, Year)
}	S.		/ Machedul T	M	D-0060	515	2/14/05
\	136		30. Name and address of person who completed ca				1 1
	. 100		Mahesha Thimmarayappa		sternshore Salisl	oury MD 2	21804
	Sta Registr		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	f		

				State of Maryland / Department of Health and N	lental Hyg	giene		
				1 - State Certificate of Death		Reg. No. 2	15	05052
	п	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day	Year	3: Time of Detath
	7	/Media		DAVID RAOUL MARBURGER	<u>a</u>	/3	05	5 25/4 "
		Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County o		
				ATLANTIC GENERAL HOSPITAL BERLIN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth		ORCES	STER
		Funeral Director		1 De 2 F 56 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day		Countr	y) .
	5.			217-50-8111 Usual Residence of Decedent	4-07-	-48	M	AINE
		anyland show		10a. State 10b. County 10c. City, Town or Location			100	d. Inside City Limits
		Man Firsh	to	MD. WORCESTER WHALEYVILLE,				1 ☐ Yes 2 ☐ No
		ith the M or 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Countr	y?
		23e c	a D	7901CIRCLE ROAD 21872		US	Δ	
		er death with the Maryla Items 23a or 28a-f ehor net must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- Americal	
	98	or It	F	1 Never Married 2 Married 1 Yes 2 1 Yo		Specify:		
	5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-1 ehow ther, the Medical Examinar must be ristified at	d by	3 □ XVidowed 4 □ Divorced Year or Dates:			UCA	
	5	nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NDT use retired)	ing	16b. Kind of Bus		
S	2121	within	E G	Elementary/Secondary (0-12) College (1-40r 5+)				LFORD
55	9			12th LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	PRESSI Maiden Surname		PLANI
35	an	S la b	To Be	EDWIN LOUIS MARBURGER ARZI	LLA G	RANT		
•	Maryland	d 2 should be th and Mental 7 is marked of traumatic eve	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Numbe	r, City or Town, S	State, Zip C	Code)
43		= E N =		KAREN ADAMS / Sister 7901 CIRCLE ROAD.	WHALEY	VILLE,	MD.	21872
3/13/08	altimore,	es 1 and of Health f Item 27 r other tr		20h Place of Disposition (Name of	16/05	20c. Location - C		
1	E	Pages nent of I int: If It	1 8	1 □ Burial 2 □ Xemation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Salisbury Crematory	10/03	SALISBI	IDVM	0 21801
62	ati	permit. Pag Department Important: t eny injury o	10	21. Sign tur-yof uneral Service Licens 22. Name and Address of Facility	DLLEY	MEMO R		
	œ	88 5 8		Totala D. Jollan 1213 JERSEY RD.	SALIS	RIIRY N	IAL C	1801 —
	в			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,		Approximate nterval Between
7		Physician		Immediate Cause (Final disease or condition				Onset and Death
	1	/Medical		resulting in death) Due to (or as a consequence of):				
	П	Examiner		Immediate Cause (Final disease or condition resulting in death) A Month of the condition of the conditions, b. Longeston in the conditions, b. Longeston in the conditions, c	re			3987-1
1118		Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				/
00		and -tran	кап	resulting in death) Last Due to (or as a consequence of):				····
50	8760,	i be executed sician and burial-transit		330.10 (3.42.33.1043.13.33)				
1		ate hy:	dlcal	d				
43/	9 xo	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date	of delivery	,
35#	Bo	atter atter	clar	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		Mon		ay Year
57	o.	that the d ed by the detached	lys	1 Yes 2 No 9 Unknown				
Yarburger	0	es that igned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.	23e. Did to	bacco use contri	bute to the	cause of death?
5	Records,	w requires been sign should be	d b		1 🗆 Y	es 2□No	3 🗀 Probat	bly 4 ≧U ńknown
79	000	s bee	olet		24a. Was	an 24b. W	ere autops	sy findings available pletion of cause of
6		The law te has	Completed		autop perfor 1 Yes	med? de	eath?	
2	Vital	ysician: The Is certificate ha director, page	O	25. Was case referred to medical 26. Place of Deat				
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2	n of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending 28b. Date of Injury 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe h	ow injury occurre	d	
avia	ioi	Attending or death.	atlc	2 Accident investigation M 1 Yes 2 No				
000	Division	after de Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Numbe m, State)	r or Rural I	Route Number,
[-]		urs af						
		the Hospitel or nin 24 hours afte the Funerel Diru npletely filled in 1	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)	red at the time,	cause(s) and man date and place, a	ner as star nd due to t	ted. he cause(s)
		To the Hospitel or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Da	ay, Year)
		- s + ō		1 1 20 1 ph. sicis_ 444382		2/12/	0.5	
		100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0,101	· · · ·	
		10		Robert Darker 9733 Healthury Drin	P 1	Berlen	- 1	40
	÷	Sta Regist	ate	31. Date filed (Month, Day, Year) FEB 16 2005 Stephen M. Charles The Control of the Control of			*	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February Donald T. Morgan 4:20 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City 5400 Montgomery Road Howard 8. Date of Birth (Month, Day, Year) Oct 25, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. 1933 579 46 4881 71 Washington DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macical Examinar must be notified at 1 Yes 2X No Directo Howard MD Ellicott City 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 5400 Montgomery Road 21043 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status iled within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 Yes 2 KNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be 1 nent of Health and Mental I int: If item 27 is marked o Thomas Chester Morgan Frances McGhan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Montgomery Road Ellicott City, MD 21043 Annette G. Morgan/Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of himportant: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State Metro Crematory 2-11-2005 * 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD permit. 21. Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Onset and Death Immediate Cause (Final disease or condition resulting in death) medice years Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 1 Yes 2 XNo or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PINE HALTS AVE. BAKTO MD 21229 AHAM 1001 Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

		_ FOI	partment of Health and Mertificate of Death	lental Hygie	•
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	
Physicia /Medic		Allen Lloyd Moulton		February	
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		St. Mary's Hospital	Leonardtown		St. Mary's
Funeral Director		5. Social Security Number 6. Sex 1 MM 2 日 F 7. Age (In yrs. last birthda, 57 Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) 5-26-194	9. Birthplace (State or Foreign Country) 47 Massachusetts
show	o.	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th the N or 28a-1	Funeral Director	Maryland St. Mary's Great M 10e. Street and Number	111S 10f. Zip Code	100	g. Citizen of What Country?
ath wi	ral	45830 Highway To Heaven Lane	20634		Inited States
Ind 21215-0036 be filed within 72 hours after death with the Maryland Ital Hyglene, and other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Fune	11. Marital Status 1 □ Never Married 21 Marned 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours all appariment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examples.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work. DO NOT use retired)	ing 16	Sb. Kind of Business/Industry
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/lar	ToB	Arthur Moulton	Marie l	D. Bonin	
Maryla d 2 should th and Men T is marke traumatic					City or Town, State, Zip Code)20634
9, N l and sealth im 27			30 Highway To Heave		Great Mills, MD
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it. Partmentrant:			e $1d ext{-Echols} + 2 ext{-}18$ 22. Name and Address of Facility Bri		Charlotte Hall, MD
Baltimore, M. permit. Pages 1 and 2 Department of Health important: if item 27 is any injury or other tra			2955 Hollywood Road	l, Leonar	dtown, MD 20650
Section 1995	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate also (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	In Forctson		Nours
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ding P	lon	27. Manner of Death 1 Salatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how	injury occurred
Divisien of Vita To the Hospitat or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, set building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Hospitat 24 hours a Funeral III	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dead on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and procurred at the time, date and place, and procurred at the control of the contr	and due to the caused at the time, date	se(s) and manner as stated. o and place, and due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certiffer	29c. License number		. Date signed (Month, Day, Year)
	}	30. Name and address of person who completed cause of death (Item 23a) (Type			ebruary 24, 2005
		Angelo Falcone, M.D., 25500 Poin		nardtown	, MD 20650
Stat Registra	-	31. Date filed (Month, Day, Year) FEB 2 5 2005 32 legistrar's Signature	a de la companya della companya della companya de la companya dell		

Daniel Min 05-1320 DOS

1320			State of Ma	ryland	/ Depa	artment of	Health an			-	
		1- State Unpend Item	23a&27 per	me G8	342 _{Ce}	าเกิรูลิโอ อีก	Death	a montan	Reg. N		
		Decedent's Name (First, Middle, Las						2. Date o	f Death	Pay Year	3. Time of Death
Physici /Medi		Daniel Tae You	ing Min					Febru	ary	19, 2005	2151 p
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Funeral Director			M 2□F / 1298	(III yrs. Ias	Yrs.	Months Days		Min. (Month	, <i>Day</i> , Yea	2004 Ba	ithplace (State or Foreign Country) 1timore, Md.
D .		Usual Residence of Decedent	21							2004 Da	
arylar ehow	-	10a. State 10b. County Md Anne Arundel		•	Town or Lo Llers						10d. Inside City Limits 1 Yes 2 No
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death with the Maryland ms 23a or 28a-f ehow rnust be notified at	i Dir		load			2110	8		USA		,
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or Ite		1X Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give	0		1 □ Yes 2 □ No		deno i nean, etc.	,	Specify:	Asian
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Executive roughs, confiled at	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:						16h	Kind of Busines	
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nd Z	BeC	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Mi	ddle, Maide	en Sumame)	
Marylan 2 should be 1 and Mental Is marked o raumatic eva	2	Young Tae Min					Youn	<u> </u>	Son		
Mar 12 sh h and 7 la m rraum		19a. Informant's Name/Relationship (7 Young Tae Min	_{Гурв, Print)} (Father)			ng Address <i>(Stree</i> Craver Ro				or Town, State, 21108	
C = M L		20a. Method of Disposition	(Facilet)	20b. Plac	ce of Dispo	sition (Name of		Date	-	Location - City o	
Baltimore, bermit. Pages 1 at Department of Hea Important: if itam any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Second)	Removal from State		netery, crer copoli	natory or other pla	1	/23/05	,	Alex. V	'a
Baltimo permit. Page Department o Important: if any injury or		21. Signature of Funeral Sovice Licen	111	Meti	22	. Name and Addr	ess of Facility (Charles			al Service
n ggragg			Hand8							oro Md	20772
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. e.	Do not ent	er the mode of dy	ing, such as ca	rdiac or respirato	ry arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Complicati	ions (Of V	iral Gas	troente	ritis			Onset and Death
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uted d ansit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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y se	licai		d								
	by Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnanc	~v					20d Date of d	- linear
Box eath cert attendin for use	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at 1	2 Fetal d	leath 3[Ectopic pregnand Other (specify)	су			23d. Date of d Month	Day Year
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ould t								_	I ☐ Yes	2 ∮ 2 No 3□F	Probably 4 Unknown
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The The cate h	Son							1 /	es 2 1		s 2 No
f VItal Hoysician: The sis certificate had director, page	Be	25. Was case referred to medical examiner?	Hospital:	NH = .	2/2 : .:	0	ther	Death (Check o		- 504 - 10	
VISION Of VITA Attending Physician: or death. actor: After this certifica by the funeral director.	To To	1 ☐XYes 2 ☐ No 27. Manner of Death	28a. Date of Injur	y 2	8b. Time o	28c. Inj	ury at	ng Home 5 ☐ I 28d. Desc		jury occurred	өсіту)
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- S - 0		Dame by Kan	thall non			0	CME		Feb:	ruary 20	, 2005
		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,		-			• •	1 1 01 001
		tamela E. South	rell mis	de Cie		111 P	enn Str	eet Ba.	Ltimo	re, Mary	land 21201
St Regist	ate	31. Date filed (Month, Day, Year) FEB 2 4 2005		ir's Signatu		P. A					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene
Registrer

State of Maryland / Department of Health and Mental Hygiene
Registrer

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 11:30 A^M 2005 HARRY EARL MURRAY, SR. Feb. 12, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) RD 10117 Keyser Point Ocean City Worcester Lee's Almost Home 8. Date of Birth (Month, Day, Year) Oct. 28, 1913 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Hours 91 Maryland 217 03 8478 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Ocean City Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number RD 21842 U.S.A. Lee's Almost Home 10117 Keyser Point 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poultry Grower Poultry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lizzie E. Hudson Harry McLeary Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Berlin, MD 11410 Gum Pt. Rd. 21811 Harry Earl Murray, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. I mortant: If Item 27 is marked other than "natural", or items 23s or 2. Apple in yor other traumatic event, the Mudical Examinar manapage. Physician

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

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f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Macheal Examination and the profilled at

Baltimore, Maryland 21215-0036

the Maryland

/Medical Examiner The law requires that the death certificate be executed

as the detached filled in by the funeral

Division of Vital Records, P.O. Box 68760

1 Burial 2 □ Cremation 3 □ Remo '4 □ Donation 5 □ Other (Specify)	oval from State	een Ce		eb.16,2005	Berl	in, Ma	ryland
	shah	108 W	illiam St.	uneral Ho Berlin, N	AD .	21811	
23a. Part1. Enter the liseas , or complicati shock, or heart filure. List only one c		t enter the mod	le of dying, such as	cardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)	^					Lycar
Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence of)		10000				0
d							
in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 9□Unknown	3 Ectopic p 5 Other (sp			23	d. Date of deli Month	ivery Day Year
Part II. Other significant ounditions contrib	uting to death but not resulting in t	he underlying o	ause given in Part I.		_		the cause of death?
Ancomia		- .		1	Yes 2	3 □ Pro	obably 4 🗆 Unknov
				24a. Was auto perfo 1 🗆 Yes	ormed?	death?	itopsy findings availab completion of cause o 2 No
25. Was case referred to medical examiner?			26. Place	of Death (Check only	one)		
1 ☐ Yes No Hosp	oital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 D	OA Other: 4 Nu	rsing Home Res	dence 6	Other (Spec	cify)
27. Manner of Death Adaptaral 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 2 ury M	28c. Injury at Work? 1 Yes 2	28d. Describe	how injury	occurred	
3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factor	y, office	28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar

24 hours e

within 2 To the

29a. Certifier

29b. Signature an

30. Name and ac

title

31. Date filed (Month, Day, Year) 5 2005

ted cause of death (Item 23a) (Type, Print)

Agistrar's Signature

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of ertificate of			iene	3 pro
	Physici /Medi		1. Decedent's Name (First, Middle, Las Joseph Mazia	st)				2. Date of Dear Month 02		Gear 2:15 A M
	Examir		4a. Facility Name (If not institution, given Casey House			Rockvil			4c. County of	omery
	Funeral Director		5. Social Security Number 6. S 179-03-0603	9X 7. AQ X M 2□F	ge (In yrs. last birthda 90 Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day 08/23/1	914	B. Birthplace (State or Foreign Country) PA
	e Maryland la-f show	Director	MD 10b. County Montgome	ry	10c. City, Town or Chevy Ch					10d. Inside City Limits 1 A Yes 2 No
	ath with th		10e. Street and Number 8401 Freyman Dr			10f. Zip Code 20815			Og. Citizen of Wh United S	States
9036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or itams 23a or 28a-f show other than "natural", or itams 23a or 28a-f show event, the Medical Examble must be routified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 If Yes, Give Year or Dates:	Ever in U.S. 13	8. Was Decedent of If Yes, specify Cul 1 Yes 2 No		pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
21215-0	d within 72 h giene. Ir than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Giv 5+)	edent's Usual Occu re kind of work done DO NOT use retire mical Eng	during most of wo	rking	16b. Kind of Busi Engineer	
yland ;	2 should be filed and Mental Hygi ie markad othar aumatic evant, I	To Be C	17. Father's Name (First, Middle, Last) Aaron Mazia			·	18. Mother's Nar Bertha	ne (First, Middle, M Kurtz	Maiden Sumame)	
Man	12 sho h and 7 ie ma trauma		19a. Informant's Name/Relationship (1			iling Address (Stree				
Baltimore, Maryland 21215-0036	Pages 1 and 2 should been of Health and Ment int: if itam 27 te markactry or other traumatice		Deborah Linda Maz 20a. Method of Disposition 1 ☎ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Removal from State	20b. Place of Disg	ematory or other pla	ace)	Date :	a Park, 20c.Location-Ci Olney, M	ty or Town, State
Balti	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral S. rv. e Li en	una		22. Name and Addr		Ave Sil	ver Spri	ng,MD 20904
	Physician /Medical Examiner		28a. Part1. Enter the disease, or companies to the companies of the compan	one cause on each li a. <u>Rena1</u> F	ne.	nter the mode of dy	ing, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death Weeks
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.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date o Month	
<u>α</u>	es pe pe	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	37	ite to the cause of death? Probably 4 □Unknown
Il Records,	The law ite has b	Completed						24a. Was ar autopsy perform 1 Yes 2	/ prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	Phyaician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot		th (Check only one		
Division of Vital	ing Afte une	ation: To	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Inju	ry at	ome 5 Reside		(Specify) Hospice
Divis	i i i i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Example Medical Example 1	ysician: To the best liner: On the basis of and manner sta	of my knowledge, dea f examination and/or i ated.	ith occurred at the ti nvestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)
ı		Me	29b. Signature and title of certifier	payal.		29c. Licen. BR 4	se number 216114		d. Date signed (A 2/14/200	
	30		30. Name and address of person Made Chitra Rajagopal,				ckville,	MD 20855		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 20	05 Registr	ar's Signature	all				

			For State Registrar	State of	Marylan		artmen rtificate				lental Hyg	iene	05	06959
	Discrete:		1. Decedent's Name (First, Middle	le, Last)					•	-	2. Date of Deat Month	h Day	Year	3. Time of Death
Ų.	Physici /Medio		Virginia G. Mara	io							February			2:15 P M
	Examir		4a. Facility Name (If not institution	n, give street and numb	ber)		4b. City,	Town, or	Location of	of Death		4c. Cour	nty of Death	
			Holy Cross Rehab						onsvil				tgomery	
	Funeral Director		5. Social Security Number 578–18–5930 Usual Residence of Decedent	6. Sex 7 1 ☐ M 28€ F	. Age (In yrs. I	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Oct. 24,	Year) 1919	9. Birth Cou Washi	place (State or Foreign ntry) ngton, DC
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Many	ğ	Maryland Mor	ntgomery	Sil	ver Spr	ing							1 ☐ Yes 2 🔀 No
	r 28e	rec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	of What Cou	ntry?
	h witi	al D	10228 Conover Da	rive			20	0902				USZ	A	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 ☐ Yes 2	es? (X)No		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:		ecify Yes or No- Rican, etc.)	B	ace - Amerilack, White	etc.
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	al Hygie I other vent,	Be (17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	e (First, Middle, A	Aaiden Suma	ame)	
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Balt	permit. Deporte Importe any nj		21. Signature of Funeral Service	Licensee By	0						ral Home : Silver Sp	Inc.		
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N C	ding F h. After funera	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pendir		Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury occu	nried	
Division	or Attendent fler deat Director: in by the	Certification;	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	f Injury - At ho , etc. <i>(Specify</i>	me, farm, str	M eet, factory		'es 2 □ !	_	28f. Location (Str. City or Town	eet and Nuπ , State)	nber or Rura	al Route Number,
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	F ₹ F 8		Diameri (Bu 5211	i m	. n				22.		_		14,2005
7	2		30. Name and address of person	who completed cause	of death (Item	23a) (Tune		25mi	347 ne C	hen	Gatti	MD	4	1,500
	,		7616 P	lassena	Rdo	rd,	BeH			1	JD "	1805	7	
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signat	Le Sp	witi							

			For Stata Registrar	State of	Marylar	-	artment tificate			and M	ental Hygi	ene g. No 2 (05	06960
	Physicia		1. Decedent's Name (First, Middle, La		+1						2. Date of Death Month February	Day 2	.0055	3. Time of Death L1:38 A M
	/Medic Examin		4a. Facility Name (If not institution, giv	May			4b. City,	Town, or	Location o		redicing y		ty of Death	1 -0
	Examin	er	Washington Count			:		erst				Wash	ningt	on
	Funeral Director		218 02 8189	Sex 7. □ M 2 🗓 F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, April 7	Year) ,1954		nplace (State or Foreign untry) ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation			-				10d. Inside City Limits
	Many -f sho	tor	Maryland Washi	ngton		Hag	ersto	wn						1 ☐ Yes 2 No
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	ath wi	rai	11806 Linbar Dri						21742			USA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28a-f show any figury or other traumatic avent. It is Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedo Armed Force 1 XYes 2 If Yes, Give Year or Date	es? No	l	Was Deced fYes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	Bla	ice - Amer ack, White ify: Wh	
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lan	fental fental rked tic av	To Be	William G. Sower	s, Sr.						Eve:	Lyn K. W	ilson		
lary	2 shot and N la ma auma		19a. Informant's Name/Relationship	•							/ Route Number,			
	is 1 and 2 of Health ar itam 27 la other trau	,	Michael F. Martin	- husba		118 Place of Dispo			Dr.		gerstown	, Md. Oc. Location		
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9	ing phy as th	Physician/Medical	IF FEMALE:										1	
Box	death certifica e attending plad for use as t	lan/l	23b. Was decedent pregnant in the past 12 months?		me of pregna h 2 ∏Feta nt at time of c	ildeath 3□	Ectopic pre						ate of deliv Ionth	/ery Day Year
o	0 0 D	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknow		ieatii 5	J Other (Spe							
Vital Records, P.	98	by	Part II. Other significant conditions of Multiple Sch	en .	th but not res	ulting in the ur	nderlying ca	ause give	en in Part I.			acco use con	atribute to	the cause of death?
CO	> 0 0	Completed	Neurogenic		r						24a. Was an	24b.		opsy findings available
Re	9 4 9	mo	chronic Follo			,					autopsy perform 1 Yes 2	ed?	death?	ompletion of cause of 2 No
/ita	yaician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					ll a		of Death	(Check only one	•		
of \	dis is	ပ္	1 ☐ Yes 2 💢 No	Hospital: 1 XIng		ER/Outpatien		_	-40140	-	ne 5 Resider			rfy)
	ding f h. After funer	tlon	27. Manner of Death 1 Natural 5 Pending investigation		Day Year)	Injury	M	Bc. Injury Work 1 □ 1	di (? Yes 2∐I		od. Describe not	v irijury occu	11190	
Division	l or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	e 28e. Place o	f Injury - At h	ome, farm, str		, office		1			ber or Rur	al Route Number,
Ö	s after al Director	Certification:	4 Homicide	building	, etc. (Specil	<i>Y)</i>					City or Town,	State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (nysicien: To the b miner: On the bas and manne	is of examina	tion and/or inv	/estination	in my or	ninion dear	th occurr	ad at the time da	onela bace of	and due t	to the cause(s)
L.	withi To the	Σ	29b. Signature and title of certifier	,			290	License	number		29	d. Date sign	ed (Month,	Day, Year)
•			Madu M Nh	eador	MD.		1	145	556	3	Te	bruar	y 4	2005
~ ^	H - 10		Radu M. Theadoru	completed cause	of death (Iter	1 23a) (Type,	Print)	tues	+ C.	to 20	2 14.	oct.	11-	wend 217/m
	Sta	te	31. Date filed (Month Dap Your)	200F 32. P	gistrar's Signa	/TM L/EL	M S	-1556	241	iezu.	- Hager	SLOVA	mar	2005 2005 Yland 21740
150	Registr		1	2005	elia.	1. P.	rete							

			1 - For State Registrar	State of Maryland		irtment of H			ene	
			Decedent's Name (First, Middle, Last)					2. Date of Death	6000	3 Time of Death
	Physici		Estella	Grace		Moyer		Month February	Day 16, 2005	7:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
		•	Cumberland Vil	la Nursing Cer	nter	Cumbe	rland		Allega	ny
	Funeral		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign
н	Director		214-12-3374	M 2 A F 95	Yrs.	34,0		11/14/19	90 9 Mary	land
	put *		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation				I Od. Inside City Limits
	fanyla	ច	MD Alle			mberland				1⊈ Yes 2 No
	28a-1	Director	10e. Street and Number	54117		10f. Zip Code		10	g. Citizen of What Cou	ntrv?
	with		629 Shriver Av	enue			1502		USA	,
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show than "natural", or Itams 23a or 28a-f show fre Madical Exertified at	Funeral		2. Was Decedent Ever in U.S	5. 13. V	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp	ecity Yes or No-	14. Race - Ameri	can Indian,
(0	r Itar irer	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		**		Rican, etc.)	Black, White,	etc.
93	al', o	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		☐ Yes 2Ñ No	Specify:		Specify:	White
21215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occupa	uring most of work	ing 16	6b. Kind of Business/In	dustry
7	ithin se.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired;				
2	led w lygier har th		6		Н	omemaker	10. Mathoda Nam	o (Eirat Middle M	Homemak	er
gue	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)	Coughe	nour		E11a	e (First, Middle, Ma May		essner
ž	d Mer nark	٦	Alexander 19a. Informant's Name/Relationship (Type			a Address (Street a			City or Town, State, Zip	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or Items 23a or 28a-f show appringury or other traumatic avant. The Modical Examination and be notified at ODGe.		Dorothy M. Bolinge			Talcott A				
ē,	Heal Heal tam S		20a. Method of Disposition	20b. Pf	ace of Dispo:	sition (Name of			Dc. Location - City or To	
оп	ages ent of tt: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 3 ☐ Other (Specify)	emoval from State	-	natory or other place e's Cemet	-	9/2005	Cumberlan	d MD
Baltimore,	artme ortar injur		21. Signature of Juneral Service License							Home, P.A.
ñ	Dep Imp		Kolut C. H	elu-					rland, MD	21502
			23a. Part1. Enter the disease, or comple shock, or heart failure. List only on	cations that caused the death	. Do not ente	er the mode of dying	, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	TRIEL	1=1	17 A				Onset and Death
-	/Medical		resulting in death)	Due to (or as a consequ	ence of):					_ /,
П	Examiner		Sequentially list conditions.							
	sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	anda of):					
	and and I-tran	хап	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):					
8760,	icate be executed physician and s the burial-transit	alE		,-	, .				1	
687	ficate phys s the	edical								
Box (death certifica attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnar					23d. Date of delive	ery
ň	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
Ö.	t the by the	hys	9 🗆 Unknown	9□ Unknown					1	
e, G	res tha igned be del	by P	Part II. Other significant conditions con	tributing to death but not resu	Iting in the un	derlying cause give	n in Part I.		cco use contribute to the	
ğ	w require been sij should t	per	· +)EN/EN [1]	4, ATPE	K(E	-142/6/	√	1 🗆 Yes	2 🖳 1√0 3 🗆 Prob	ably 4 DUnknown
ecc	law ras be	ple						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u>ш</u>	The ate h page	Con						performe 1 ☐ Yes 2 ☐	ed? death? ∃No 1 □ Yes	212No
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	- entel		Othio		h (Check only one)		
of	Physician: r this certifica ral director, I	5	1 195 2 2 2 140	1	R/Outpatien 28b. Time of	3 □ DOA Othe	AND INUISING HO	me 5 Residen	ce 6 Other (Specif	y)
uc.	ding h. h. After funer	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	? ′es 2 □ No	Edd. Doddilbe Now	injury occurred	
<u>is</u>	death ctor: /	lical	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, stre				et and Number or Rura	I Route Number,
Division of Vital Records,	after after Dira	Certification;	4 Homicide	building, etc. (Specify,)			City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	alC		ician: To the best of my know						
	n 24 n 24 ha Fu	ledical	(Check only 2 Medical Examinone)	er: On the basis of examinati and manner stated.	on and/or inv	estigation, in my op	inion, death occur	red at the time, date	e and place, and due to	the cause(s)
	To the composition	Σ	29b. Signature and title of certifier	1/1		29c. License	number	/ 290	d. Date signed (Month,	Day, Year)
•			Som	Klass	w.	DOO	54004		2/16/2	2005
	53		30. Name and address of person who co							
			Shiv C. K 31. Date filed (Month, Day, Year)	hanna, M.D.,		National	Highway,	LaVale,	MD 21502	
	Sta Registr		FFB 1 7 2		H	love the				
			11111 1 (/	1111.3 85.20 200 200 200	E 32 R.	AND THE PROPERTY OF THE				

			State of Maryland / De 1- State Amended #1 per MD; FCHD TM02/E	epartment of Health and N Selrtifleate of Death	fental Hygier	0.00
	Physicia	an	Decedent's Name (First, Middle, Last) Applonia		2. Date of Death	3. Time of Death
	/Medic	al	MARTHA APPLONE M 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		13, 2005 8:30 P M
	Examin	er	421 Birmingham Drive	Frederick		Frederick
	Funeral Director		5. Social Security Number 579-01-7669 6. Sex 1 M 2 F 7. Age (In yrs. last birtho	Months Davis House Min	8. Date of Birth Apr. 20,	9. Birthplace (State or Foreign Country) Maryland
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	r Location		10d. Inside City Limits
	Mary B-f sho	tor	Maryland Frederick Frederi	.ck		1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 421 Birmingham Drive	10f. Zip Code 21701	10g.	Citizen of What Country?
	ms 23	erai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or Items 23a or 28a-f show event. The Mccleal Examiner must be notified at	b	Armed Forces? 1 ☐ Never Married 2 ☑ Married If Yes, Give A 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
5-0	72 ho "natur	Completed	(Specify only highest grade completed) ((ecedent's Usual Occupation live kind of work done during most of work		. Kind of Business/Industry
121	e filed within al Hygiene. I other than " vent, ine Ma	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NDT use retired) Machinist	1	Universal Plastics
nd 2	e filed al Hygid I other vent. II	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
ylaı	2 should be and Mental is marked o	To	George Washington Burroughs	e Lorrain		
Mar	s 1 and 2 should f Health and Men item 27 is marke other treumatic			lailing Address (Street and Number or Rur. Birmingham Drive,		
ore,	es 1 and 2 of Health I item 27 i r other tre		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
altimore,	Pag tment tent: I		'4 □Donation 5 □ Other (Specify) Resthan	en Mem. Gardens 2/1		ederick, Maryland
Bal	permit. Pages. Department of the Importent: If ite any injury or of once.		21. Signature of Filmera , ervice (new	ROBERT E. DAILEY & 1201 NORTH MARKET S	SON FUNERA	AL HOMES, P.A. RICK, MD 21701
	5 01		23a. Part. Enter the disease, or complications year cased the death. Do no specified Cause (Final List only one dause on each line).	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	TIC Squamous Cell	CARCINEMA	y sein 5 years
	Examiner		Sequentially list conditions, b.			
	ed sit	Examiner	l any, leading to immediate cause. Enter Underlying Cause (is eas a consequence of cause (is eas a consequence of cause (is ease or injury			
C.	execut in and ial-trar	Exan	that initiated events resulting in death) Last c. Due to (or as a consequence of)			
8760,	cate be executed oblysician and the burial-transit	dicat	d			
9	death certifica attending ph d for use as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
O. Box	requires that the death certifii een signed by the attending p hould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
, P.O.	s that to ned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ords	w requires that been signed to should be det		Deep Voros Thrombophle	biris	1 ☐ Yes	2 No 3 Probably 4 Onknown
Vital Records,	e law has b	Completed			24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?		(Check only one)	
of	ys o	1: To	27. Manner of Death 28a. Date of Injury 28b. Tim		me 5 Residence 28d. Describe how in	
ion	Attending ir death. ector: After by the fune	ation	1. ☑ Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation			
Division of	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	spitel ours a nerel D	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	eath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospitel within 24 hours of To the Funeral I	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.	r investigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number D00 35152		Date signed (Month, Day, Year)
,	2		30. Name and address of person who completed cause of death (Item 23a) (Ty			
	7		J. L. Kranz, Mg 100	S. Center St.	Thurman	MD 21788
	Sta Registr		31. Date filed (Month, Day, Year) 6 2005 32. Registrar's Signature	pe, Print) 5. Center St.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) OMIC If Under 1 Year Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number **Funeral** Min. Hours 1 □ M 2 🖔 F Months Vrs 58 8-8-46 Md 215-48-7078 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County rithen "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at M∏Yes 2 No Director Wicomico Delmar Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21875 601 E. Pine St. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effert. Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or item eny injury or other traumetic event, the Medical Examina 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) never worked 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alma Lee Hearn Smith Ross Marvel Smith ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 E. Pine St. Delmar, Md. 21875 Ross Smith, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State St. Stephens Cem. 2-16-05 Delmar, De. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home we 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome Pnysician GUNIS /Medical Due to (or as a consequence of) **Examiner** SEVERE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Linter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit the death certificate be executed FAILURE THRIVE and Due to (or as a consequence of): P.O. Box 68760. the attending physician PO THYROIDI Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 3 ☐ Probably 4 ☐ Unknown 2 DNo 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Tyes 2 No or Attending Physician: after death. I Director: After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ٩ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funerel D the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D57952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Milford ST, # 504B, Salisbury MD 21864 M.D Babulal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 15 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 06964 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 8:24 P M McCabe 2005 13 Feb. Clay /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Atlantic General Hospital Berlin

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Oay, Year)

JAN. 19, 19 Berlin 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Yrs. 80 DELÁWARE Director 222-18-8349 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "netural", or Items 23s or 28e-1 show any injury or other traumatic event, the Marical Examinating the notified 41 once. 10a. State 10b. County 1 ☐ Yes 2 No SUSSEX Directo SELBYVILLE DELAWARE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15 HICKORY LANE 19975 USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: 1942-45 WHITE 3 ☐ Widowed 4 Z Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AGENT REAL ESTATE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be McCABE **EDNA JOHNSON** VIRGIL ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 HICKORY LANE, SELBYVILLE, DE. 19975 MARGARET FAULSTICH/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State REDMEN'S CEMETERY 2/17/05 SELBYVILLE, DELAWARE • 4 □ Donation 5 □ Other (Specify) 21. Signature It Fulleral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Mills 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DIZCIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐ Pregnant at time of death been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the firector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 100 : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 ⊡Natural 1 ☐ Yes 2 ☐ No death. n 24 hours efter death.

Be Funerel Director: A

bletely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier USICICA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Durilli-Hellhwig 9733 3 T 5 State 2005 Registrar

				For State Registrar	State o	f Maryland	-	rtment of F		Mental Hy	giene Reg. No. 0	5 0696	5
		Physici	an	Decedent's Name (First, Middle MARY ANN H.						2. Date of De Month	eath Day	3. Time of De	ath P _M
		/Medio Examir		4a. Facility Name (If not institution		mber)		4b. City, Town, o	r Location of Death	Februar	4c. County	005 1222 of Death	
				The Memoria 5. Social Security Number	Val Hosp	7. Age (In yrs. las	t hirthday)	If Under 1 Year	aston If Under 24 Hrs.	8 Date of Bir		9. Birthplace (State or Fo	oreian
	ı	Funeral Director		214-50-8998	1□M 2□F	57		Months Days	Hours Min.	8. Date of Bit (Month, Da JAN 12	1948	MARYLAND	J. O.g.
		land W		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Loc	ation				10d. Inside City L	imits
		e-f she	ctor	MD CAR	OLINE	P	RESTO	N				1 ☐ Yes 2	XNo
		death with the Maryland ms 23a or 28e-1 show	Director	10e. Street and Number 4191 ALDERMAN	DIACE			10f. Zip Code	1655		10g. Citizen of V	What Country?	
		death ms 23	Funerai	11. Marital Status		edent Ever in U.S.	13. W		dispanic Origin? (Si an, Mexican, Puert	pecify Yes or No		e - American Indian, k, White, etc.	
	36	2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. Is marked other than "nature!; or Items 23a or 28e-1 show amatic event. It we worked Examiner and the maillified at	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes If Yes, Gir	2 X No ve		☐ Yes 2 No	Specify:	0 7 110211, 010.7	Specify	THITME	
- 30	altimore, Maryland 21215-0036	72 hou nature	eted	15. Deceder (Specify only highe	nt's Education st grade completed)		(Give k	ent's Usual Occup	during most of wor	king	16b, Kind of B	usiness/Industry	
de	121	within lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired ET MANAG	<i>'</i>		STAT	E OF MARYLAN	D
lay AnnilMades	nd	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than 'appi rigury or other treumatic event, Item, once.	BeC	17. Father's Name (First, Middle,					18. Mother's Nam		, Maiden Suman	ne)	
OH,	ryla	hould I	J.	JOSEPH A. MAJ			19b. Mailine	Address (Street	HELEN and Number or Ru		EPPUTOWAL		
An	Ma,	and 2 s latth an 27 ls er treu		GARRY D. ADAMS			·		AN PLACE		•		
3	lore	ges 1 of He If item or oth		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation		State cerri	ietery, crem	ition (Name of atory or other place	1	Date		City or Town, State	
6	altin	nit. Pa partmer cortent injury		* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		CHE	22.	Name and Addre				ZENSVILLE, M	D
	ä	Depar Depar Impor eny ir			,	f.SP	20	O S. HAR	RISON ST	EASTON,	MD 2160		
	2	Fnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that of only one cause on e	each line.	Do not ente	*	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Betwee Onset and Dea	th
		/Medical Examiner		resulting in death)	Due to	(or as a consequent		incer				8 month	~5
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or Ir Jury that is its lead or very that its lead or very that is its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead or very that its lead	b. Due to	(or as a consequer							
		cate be executed by sician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequer	nce of):						
	8760	te be e lysiciar ne buria	dicai E		d								
	P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certifics within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregnanc birth 2 Tetal de nant at time of deat own	eath 3⊡i	Ectopic pregnancy Other (specify)	,		23d. Dat Mor	e of delivery nth Day Year	r
	ď.	s that I	by Ph	Part II. Other significant condition	ons contributing to d	eath but not resulting	ng in the un					ribute to the cause of death	n?
	ord	require een sig hould b	eted	Chronic C	bstructi	ve pull	~3~~	y 252	250			3 ☐ Probably 4 ☐ Unkr	
	Rec	he law e has b	Completed								psy prmed?	Vere autopsy findings available to completion of cause leath?	lable e of
	'ital	sien: T ertificat ctor, pi	Be Co	25. Was case referred to medica examiner?				1-1	26. Place of Dea	1 ☐ Yes th (Check only o		Yes 2 No	
	of V	Physic r this ce ral dire	2	1 ☐ Yes 2 ☑ No 27. Manner of Death			VOutpatient	3□ DOA Oth 28c. Injur War	4 Nursing n		dence 6 Other		_
	ion	anding ath. or: Afte	ation	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	gation	of Injury 28 th, Day Year)	Injury		k? Yes 2 ☐ No				
	Division of Vital Records,	or Atter de Directe	Certification:	3 Suicide 6 Could 4 Homicide determ	ained 200. Flace	of Injury - At home ing, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To		er or Rural Route Number,	
		e Hospita 124 hours e Funerel letely filled	Medical C		ng Physician: To the Examiner: On the b and man							nner as stated. and due to the cause(s)	
		To th withir To th comp	Me	29b. Signature and title of certifie	(),	.:~		29c. Licens			29d. Date signed	(Month, Day, Year)	
				30. Name and address of person	who completed caus	se of death (Item 2)	3a) (Type, P		1-(-1		04/13/0	<u> </u>	
				DAVID G. OLIVI	ER M.D. 50	3 DUTCHM	ANS LA		ON, MD 21	601			
		Sta Registi		31. Date filed (Month, Day, Year)	7 2005	trar's Signatur	8	Carle ;					

			Ficase	State of Mai				•	_	Jie.				
			1 - For State Registrar	otato ot mai	-	rtificate of I			g. No.?	15	060	166		
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	A1300 A37	V	3. Time of	Death		
	Physici /Medio		Howard	e, Jr.			Februar	y 21 2	Year 005	2350_	Рм			
7	Examir		4a. Facility Name (If not institution, give s				r Location of Death		4c. County of					
	Funeral Director		177 Springfield D		(In one least historia)	North I	East If Under 24 Hrs.	O Data of Blath	Ceci		101			
			5. Social Security Number 6. Sex	M 2□F 63	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 21,	Year)	9. Birthpla Counti	ace (State of	r Foreign		
			Usual Residence of Decedent)			Julie 21,	1741	пату.	Lanu			
	how	_	10a. State 10b. County	1	10c. City, Town or Lo					10	d. Inside Cit			
	8e-f s	cto	Maryland Cecil		North E	1					1 🗆 Yes	2[<u>A</u> No		
	with th	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W		-			
	eath	era	177 Springfield D:	rive 2. Was Decedent Ev	er in U.S. 13.	21901 Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	Unite	- America				
9	or Iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		, White, e	tc.			
03	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐X No	Specify:			Specify: White				
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show the Madigal Examilian mast be mailted at	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occupa kind of work done of	ation during most of work f)	ing 1	6b. Kind of Bus	siness/Indu	ustry			
12	d withir giene. rr then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		siness Ow			Conveni	ience	Store	2		
d 2	e filed Il Hygid other vent,	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M						
ılan	should be od Mental marked o matic eve	To B	Howard Earl Moore	e, Sr.			Maida	M. Heath	eath					
ar,	2 should and Men Is marke eumatic	ľ	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street a	and Number or Run	al Route Number,	City or Town, S	State, Zip (Code)			
	Health tem 27 I		Betty J. Moore/Wi	fe	20b. Place of Dispo		ld Drive,			_		01		
Baltimore,	permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg. Importent: If item 27 is marked other eny injury or other treumatic event, once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	Cherry H	patony or other plac	(a) Febru	uary	Oc. Location - C					
Ħ			'4 □Donation 5 □ Other (Specify)21. Signature of Funeral Service License	θ .	Methodis	t Cemeter	cv + 26.	2005(Cherry	Hill,	Mary	land		
Ba			1 2	Cabille	H	icks Home	for Fund	erals, P.	A.	1 o	nd 210	221		
	Inysician		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 2192 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 2192 Approximate interval Between											
4			Immediate Cause (Final disease or condition		(Onset and D	eath							
	/Medical Examiner		resulting in death)	Due to (or as a o	consequence of):									
E	le be executed ysician and e burial-transit		Sequentially list conditions, b.	Due to lor as a c	ASTAT	C Kec								
		nlne	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events	Dad to for as a c										
Ć.		Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
1760,		ical	ď.											
68 ×	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE:											
Вох	ath cattend		23b. Was decedent pregnant in the past 12 months?			1	23d. Date of delivery Month Day Year							
o.	the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ilo oi dealii - 5 L	Other (specify)								
٥	s that	by Pł	Part II. Other significant conditions cont	ributing to death but i	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	23e. Did tobacco use contribute to the cause of death					
rds	w require been sig should b	Completed b						1 ☐ Yes	1 Yes 2 No 3 Probably 4 Unkno					
Vital Records,	The law requires ate has been sign bage 2 should be		k .					24a. Was an autopsy	24b. W	ere autops	sy findings a	vailable use of		
Œ =	(0 -	Com			performe 1 ☐ Yes 2	de de 1	ath?	.□ No						
/ita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:		Otho	20	(Check only one)						
of	this ald	- T	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien	- Ademini	4 🗀 Harsing Ho	me 5 🗴 Residen 28d. Describe how						
	Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	ear) Injury	28c. Injury Work M 1 1	k? Yes 2 □ No	200. Describe now injury occurred						
Division	Attending or death. sctor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be				t and Number or Rural Route Number,							
Ö	To the Hospitel or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	Certification:	286. Place of Injury · At home, farm, street, factory, office determined 286. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street a City or Town, Sta											
	Hospitel or 24 hours efte Funerel Dir tely filled in	edical	29a. Certifier 1 Certifying Physi 2 Medical Examine	er: On the basis of ex	camination and/or inv	occurred at the tim	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, date	se(s) and manr e and place, an	ner as stat	ted. he cause(s)			
	To the within 2 To the complet	Medi	one) 29b. Signature and title of continuous	and manner stated	d. 	29c. License			I. Date signed					
	M L S) M. ()	m MD			159131	-	CBUARY			_		
7	59		30. Name and address of person who com	npleted cause of deat	th (Item 23a) (Type.	Print)		-		100)			
,	8		Thomas Dubbian,	MD 20	7 NORT	h STREE	ET, EL	KTON 1	4D 2	192				
	Sta		31. Date filed (Month, Day, Year) MAR 0 1 20	32. Registrar's	Signature	boots .		v		,				
	Registr	aı	MAR 0 1 20	UJ PROPERTY	19	ACCOUNTY OF								

			For State Registrar	State of N	Marylar		artment rtificate			and M	ental Hy	giene	0.0	giira ya	·
	Physici /Medic		1. Decedent's Name (First, Midd. Betsy	Wood	McQ	uinn					2. Date of De Month Februa	Day		ear	Time of Dealth /
	Examir		4a. Facility Name (If not institution 196 E. Chesape	ake Beach R	d.,	leas historiau		nas	Location of		0 Data -4 0	C	alver	Death Ct	
	Funeral Director		5. Social Security Number 121-24-3814 Usual Residence of Decedent	6. Sex 7 1 □ M 2 💢 F	74	last birthday) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da July 19	ay, Year)		Country)	e (State or Foreign
e, Marylan	Maryland a-f ehow	ctor	10a. State 10b. County NY Ots		10c. Cit	ty, Town or Lo							1	Inside City Limits 1 □ Yes 2 No	
	s 1 and 2 should be ilied within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exactions must be notified at	eted by Funeral Director	10e. Street and Number 552 County Ro 11. Marital Status 1 Never Married 2 Mar 3 XWidowed 4 Divorced 15. Deceder (Specify only high	nt Ever in U s? XNo s:	rer in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						- 14 5	10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry			
	iled within tygiene. her than " nt, Ine Me	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle,	College (1-40	or 5+)	life.	oo not use stered	e retired _,	se		(First, Middle		alth	care	
	should be find Mental by marked of	To Be	John A. 19a. Informant's Name/Relations	Wood	III	19b. Mailir	na Address	(Street a	Maı	rion	L. / Route Numb		Rhod		de)
	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		Iaura M. Krat: 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5	z, daughter	te C	196 E	E. Che sition (Naminatory or ott	Sapo e of her place	ake I	Beach D		Owing 20c. Loca	S M ation - City	D 20 y or Town,	0736 State
Balti	permit. Departri Imports any inju		21. Signature of Funeral Service	Ricensee Rev	5	22	2. Name and	Addres	s of Facilit	у	e, P.A.				
	Physician and physician and physician and physician the prival-transit	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, land, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Int	proximate erval Between set and Death	
.O. Box 6	ne death certifi the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 2 nonths? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	al death 3	Ectopic pre Other (spe					23	d. Date of Month	delivery Day	y Year
S, D	w requires that the bean signed by should be detact	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac							/ -	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown				
Vital Record		Completed				· · · · · · · · · · · · · · · · · · ·	.				24a. Was autor perfo		prior deat	to comple	findings available ation of cause of] No
o	Attending Physician: The la r death. sctor: Alter this certificate has by the funeral director, page 2	ertification: To Be (25. Was case referred to medical examiner? 1 Yes 2												
Division	tal or Attendin rs after death. al Director: Al ed in by the fur	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)								oute Number,				
	To the Hospital or All within 24 hours after of To the Funeral Directompletely filled in by	ledicai	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	of examina	owledge, death ation and/or in	vestigation,	in my op	pinion, deat	d place, a	ed at the time,	date and p	lace, and	due to the	cause(s)
	or vitt	Σ	29b. Signature and title of certific	s WMe	es,	MO		License	number	23	_	29d. Date	signed (M	aonth, Day,	Year)
	ID Sta	ite.	30. Name and address of person G. Moody, M.I. 31. Date filed (Month, Day, Year,	10845 32. Regi	Town	Center	Blvd.		unkir	k, M	D 2075	54			
	Registi		FER	3 1 4 2005 b	Here	M	Mag	B 8							

			For State Registrar		te of M	arylan	•	artment o				Reg. No.	005)696	58
	Physici	_	1. Decedent's Name (First, Middle	June (First, Middle, Last) Morris							2. Date of De Month	ath Day / 0	20		3. Time of 1	
	/Medi Examir		4a. Fecility Name (If not institution	give street a	nd number				wn, or Loc	ation of Death			County of D			
			COASTAL HOS	PICE	AT	THE	LAKE	SA	LISE	ury,	mD		WI	COI	mic	٥
	Funeral Director		5. Social Security Number 220-32-8001	6. Sex 1 ☐ M 2 0	D+⊏	ge (In yrs. 67	last birthday) Yrs.	If Under 1 Y		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da 6/19/1	th y, Year) 937		Birthpla Country aryl	ice (State or y) and	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo	cation						100	d. Inside City	y Limits
	Mary -f sho fied a	ţ	Maryland Wicomico Salisbury												1 🗆 Yes	2 🔀 No
	or 28s	Director	10e. Street and Number					10f. Zip Co				_	zen of Wha	Countr	y?	
	ath wi	rai	6415 Crocket					2180					JSA			
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exemples must be notified at or other traumatic event, the Medical Exemples must be notified at	i by Funerai	11. Marital Status 1 Never Married	ed 1 🗆	Deceden ed Forces Yes 2 ½ es, Give r or Dates	No	1	Vas Deceden f Yes, specify	Cuban, M	nic Origin? (Sp exican, Puerto pecify:	ecify Yes or No Rican, etc.)		4. Race - A Black, V Specify:	Vhite, et		
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo							g most of work	ing	16b. Kir	b. Kind of Business/Industry			
121	within ene.	dwc	Elementary/Secondary (0-12)	Coll	ege (1-4or	5+)	Bank		etirea)			Banl	cina			
d 2	e filed of Hygie other I	0	17. Father's Name (First, Middle,				Daile	C1	18.		e (First, Middle,	Maiden				
ylar	should be ind Mental s marked c	To B	Mcguire D. Bol								a Irma					
Ξ	1 and 2 sho Health and I lem 27 is me		Jack L. Morris								Salisb				Code)	
Baltimore,	or other		20a. Method of Disposition 1 28urial 2 Cremation		from State	_ _ 0	Place of Dispo emetery, cren inqhil	atory or othe	r place)	!	Date		cation - City			
Itim	permit. Pages 1 Department of H Important: If ite any injury or ot		 4 □ Donation 5 □ Other (S_k Signature of Funeral Service I 			Gar	deńs	. Name and A	ddress of	Facility	5/05		ebron,			
	Physician /Medical Examiner	-	22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804													ion
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death disease or condition											reen		
		resulting in death) Due to (or as a consequence of):									7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	sit s	iner	Sequentially list conditions, any landing to immediate cause. Enter Underlying Cause (Disease or injury	b	ue to lor a	s a conseq	uence at):									
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8760,	ate be executed hysician and the burial-transit	ical		d.												
9	leath certifica attending phy if for use as th	/Med	IF FEMALE:	220 If ye	e outcom	e of pregna	DOM:									
O. Box	0 9 9	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	10	Live birth	2 Fetal	Ideath 3□	Ectopic pregr Other (speci				2	3d. Date of Month	,		ear
ls, P.O.	requires that the dieen signed by the hould be detached	by	Part II. Other significent conditio	ns contributing	to death	but not res	ulting in the ur	nderlying caus	e given in	Part I.	23e. Did to	>	1	e to the	cause of de	
cor	> 400	letec									24a. Was an 24b. Were autopsy f					
Vital Records,	The law ate has b page 2 st	Completed													oletion of cal	
/ital	i ician : Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		-						ath (Check only one)					
of \	Phys this al di	은	1 ☐ Yes 2 No	Hospital:	1 Inpat		ER/Outpatien		Other: 4		me 5 Resid			Specify)		
	ding I th. After funer	tion	27. Manner of Ceath 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?								28d. Describe how injury occurred					
-	or Attendent ter deatl irector; n by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286.		njury - At ho atc. (Specif)	ome, farm, stre	et, factory, of	fice	28f. Location (Street and Number or Rural Roi City or Town, State)				Route Numb	Θ <i>r</i> ,	
-	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	29a. Certifier Check only one)	ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Il Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	vithin 2 o the	Med	29b. Signature and title of certifier	and	Manner s	ialeu.			cense nun							
	->-0		(M) PE	US	Vi	0		d.	126	278		2	-11-	0	>	
			30. Name and address of person of DAND Collette	no complete	cause of	death (Item	1 23a) (Type, I	Print)	Sal	ish	and	21	501			
1	Sta Registr	20	31. Date filod (Month, Day, Year) FEB 14	2005	32. Pagist	trar's Signa	1 23a) (Type, I	porte		0)						

			State of Maryland / Departs of Maryland / De	artment of Health and M rtificate of Death	ental Hygie	ne 005 06969
I	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) IRUNG M. NEWMYN		2. Date of Death	Day Year OO50 M
	Examir		4a. Facility Name (If not institution, give street and number) SUBULE NO HOSPITM	4b. City, Town, or Location of Death		4c. County of Death MONTGCMCY
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 148–46–8072 51 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 23,	9. Birthplace (State or Foreign Country) New York
	Maryland e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Prince Georges Belt	sville		10d. Inside City Limits 1 ☐ Yes 2√☐ No
	h with the	al Director	10e. Street and Number 4504 Blackpool Drive	10f. Zip Code 2 07 05		Citizen of What Country? Inited States
980	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23a or 28e-f show event, its Medical Exact control to notified a	by Funeral	1 Never Married 2 Married 1 Yes 2 ZNO	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	within 72 hou ene. than "nature	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) nt Biologist	05	b. Kind of Business/Industry Department of griculture
0 9		0	17. Father's Name (First, Middle, Last) Samuel Newman	18. Mother's Name	(First, Middle, Maio	den Sumame)
Maryland	od 2 shoul th and Ma 27 is mar! r treumeti	F		ng Address (Street and Number or Rura 6 Caplinger Road,		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other treumetic evonce.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cre. Shaare T	osition (Name of matory or other place) 02/08 efila/Mt. Lebanon		c. Location - City or Town, State Adelphi, MD
Balti	permit. Departm Importer any inju		21. Signature of Funeral Sarvice Literaces	orchinsky Hebrew F 54 Carroll St., NW		
	whysician and wastering the burial-transit transit al Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in the light of the	olus		Interval Between Onset and Death	
O. Box 68	ath certific attending p for use as	Physiclan/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O	juires that the de n signed by the a lid be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the use of the part o	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Anknown
		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatien	26. Place of Death		e 6 □Other (Specify)
ision	Attending death. ctor: After y the fune	Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 1/31/5 28e. Place of Injury - At home tarm, st	of 28c. Injury at Work? M 1	28d. Describe how in the slip	
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certify 1 Certifying Physician: To the best of my knowledge, deal continuous co			
)	1	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year) RIWNY 7, 2005
	35			BIKE, GOCKVILLE, M	0 20852	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) Segistrar's Signature FEB 1 4 2005	edi		

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Day, February **Physician** 2005 6:53 p DONNIE MAE NELSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lanham Prince George's 5513 Belva Place If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 27, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 83 West Virginia 579-20-2003 1921 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "naturel", or items 23a or 28e-f shov the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 5513 Belva Place 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electronics Assembly Entron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fit and Mental H Is marked of Annie Wallace Floyd Howerton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar. Important: If Item 27 Is any Injury or other treu once. Frances M. Barry - Daughter 14317 Runabout Court, #22, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation / 5 □ Other (Specify) MD Veterans Cemetery 2/17/2005 Cheltenham, Maryland 21. Signature Funeral Service Toe Se 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular heart disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐ Pregnant at time of death P.O. 9 Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examinar Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 Yes 2 No 28a. Date of Injury (Month, Day Year) After th 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 1 6 2005 Registrar

			State of Maryland / Department of Hear State Registrar Certificate of De	alth and Me eath		erie 0 0 5	06971
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Judith Nguhmbi		2/12/20		16:40 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc			4c. County of Dea	
				ever1y Under 24 Hrs.		Prince Ge	
	Funeral Director		1 M 2 N P	Hours Min.	8. Date of Birth (Month, Day, Y 2 / 2 / 196	(ear) 9. Bir	thplace (State or Foreign buntry)
			N/A 43		2/2/190	oz can	meroon, S.L.
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	B Mar	Director	MD Prince George's Ft. Wa	shington			1X Yes 2 No
	ith th	Sire.	10e. Street and Number 10f. Zip Code		10g	. Citizen of What Co	ountry?
	ath w		711 Camelot Way 207				Sierra Leon
	er de Itams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No S 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specify:	Black
Ö	within 72 hours after death with the Maryland ene. then "natural", or Itams 23s or 28s-f show he Medical Examiner must be ricitlied at		15. Decedent's Education 16a. Decedent's Usual Occupation	n	16	b. Kind of Business	
215	hin 72	ple	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) (Give kind of work done during life. DO NOT use retired)	ng most of working	9		
21	d wit giene er tha	Completed	12th Accountant			Privat	e
pu	al Hy d oth	Be (. Mother's Name			
yla	Meni Meni Meni Meni Meni Meni Meni Meni	၉	John Nguhmbi	Julie	Pile		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or itams 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Grace Nguhmbi/Sister 711 Camelot Way			,	, ,
Baltimore, N	1 and Health em 2 ther t			Da Da		c. Location - City or	
	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State			meroon, A	
	iit. Partme		^4 □ Donation 5 □ Other (Specify) Douele, Cameroon 21. Signature of Fineral Service Licensee 22. Name and Address of				
Ba	Depar Import any ir		7474 Landove				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, si shock, or heart failure. List only one cause on each line.	such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
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Вох	death certifics e attending pl id for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of del	ivery
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Ś	es On On	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.		. /	the cause of death?
ord	w requires been sign should be	ted	>epsis		1 🗆 Yes	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	obably 4 Unknown
ec	\$ 5 S	Completed			24a. Was an autopsy	prior to	topsy findings available completion of cause of
H E	Th ate pag	Co			performed		2 No
VIII.	Physician: Th this certificate ral director, pag	Be	examiner? Hospital:	3. Place of Death			
of	Phys ral di	. To	1 Yes 2 No Tospital 1 Inpatient 2 ER/Outpatient 3 DOA Total 1 Input 2 ER/Outpatient 3 DOA Total 27. Manner of Death (Month, Day Year) Injury Work?		e 5 🗌 Residenc 3d. Describe how	e 6 Other (Specinium occurred	cify)
on	ding th. After funer	tlon		2 □ No		,,	
Jivision of Vital Record	l or Attending after death. Director; After in by the fune	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28	If. Location (Stree	t and Number or Ru	ıral Route Number,
ă	a after	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town, S	rare)	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director; After completely filled in by the funer		29a. Certifier (Check only (Ch	date and place, ar	d due to the caus	se(s) and manner as	stated.
	the H in 24 the Fi	edical	and manner stated.	on, death occurred	at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License nu		29d.	Date signed (Month	n. Day, Year)
			DO 3200 000436	62		4/15/0	5
R	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Jospita	1Dr	hovorl	20785 JMD
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7 2005	mprice	11 11 (<u> </u>	1-12
	. negisti	ai	LEDIT LOUD TOOK & COOK				

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Ma

aryland / Department of Health and Mental	Hygiene)	n	n	E.
Certificate of Death	Reg. No.	U	U	1

2. Date of Death

29c. Licensa number

D 46 962 FEBRUARY 11, 2005

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Fund of the part o		Physic	ian	Decedent's Name (First, Middle, L	.ast)				2. Date of De Month.	Day	Year	3. Time of Death
Function Control Con				Rosalie Oliver			T., ., .					1805
Common Department Departm		Exami	ner									
Part Part				Peninsula Legia				lisbury	Wicomic		CO	
The control of the co							Months Days	Hours Min	. (MONIN, Da	th ay, Year)	9. Birthp	place (State or Foreig ntry)
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The composition of the composi	<i>M</i>	deg	ner	11. Marital Status	12. Was Decedent	12. Was Decedent Ever in U.S. 13. W		Hispanic Origin? (9	Specify Yes or No)- 14. Ra	ce - Americ	
19 10 10 10 10 10 10 10	0		by Fu		1 ☐ Yes 2 🔯 If Yes, Give				to Alcan, etc.)			
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Physician Medical Examiner 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of typic stands and activities that the mode of typic stands are conditions as a consequence of the medical Examiner 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of typic stands are caused the d	5	mit.		21. Signature of Funetel Service Lie	OF \$ 00						-, 55	
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24a. Was an autopsy performed? 1 yes 2 No No No No No No No		S, es th	ρ	Part II. Other significant conditions	contributing to death b			iven in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?
24a. Was an autopsy performed? 1 yes 2 No No No No No No No		oquir oquir ould I	ed	Acuie K	ENAL	FAILU	ICE		10'	Yes 2⊠No	3 🗌 Prob	ably 4 □Unknown
25. Was case referred to medical examiner? 26. Place of Death Check onlone 27. Manner of Death 28. Date of Injury 28. Injury at Work? 27. Manner of Death 28. Injury at Work? 28. Injury at Work? 3 Suicide 4 Homicide 28. Place of Injury 4 Homicide 28. Injury at Work? M 1 Yes 2 No 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Certifier 29. Certifier 20. Certifier 21. Certifying Physician: To the best of my knowledge, death occurred at the time date and clace and due to the cause(s) and manner as stated.		s be	olet	DEMEN	TIA				24a. Was	an 24b.	Were auto	psy findings available
25. Was case referred to medical examiner? 26. Place of Death Check onlone 27. Manner of Death 28. Date of Injury 28. Injury at Work? 27. Manner of Death 28. Injury at Work? 28. Injury at Work? 3 Suicide 4 Homicide 28. Place of Injury 4 Homicide 28. Injury at Work? M 1 Yes 2 No 28. Location (Street and Number or Rural Route Number, City or Town, State) 29. Certifier 29. Certifier 20. Certifier 21. Certifying Physician: To the best of my knowledge, death occurred at the time date and clace and due to the cause(s) and manner as stated.	1	He la	E						perfo	rmed?	death?	
29a. Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated		In: T		25. Was case referred to medical				00 Pt 4 P-			1 L Yes	2 No
29a. Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	:	aicla cert	00	examiner?	Hospital:	2 TER/Output	2C DOA Ot					
29a. Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated	•	Phy r this	H .				of 28c lou	4 ∟ Nursing F urvat				0
29a. Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated		SION tending eath. or: Afte the fune	cation	1 Natural 5 Pending 2 Accident investigati	on		y Wo	ork?]Yes 2 □No				
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		Blor Att	Sertifi	datamina	d 286. Place of inj	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Numi vn, State)	ber or Rura	l Route Number,
Check only 2 Medical Examiner: On the basis of examination and/or investigation in my eninion, death occurred at the time, date and aleast and date and date and date and date and date and date and date.		lospil 4 hour uner		29a. Certifier 1 Certifying F	Physician: To the best	of my knowledge, de	eath occurred at the t	ime, date and place	a, and due to the	cause(s) and m	anner as st	ated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 1 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REGIONAL MEDICAL CENTER. MD & M. SHIRAZI, M.D. PENINSHLA REGIONAL MEDICAL CENTER. MD & 100 E. CARROLL ST. Splis. Md

			1 - For State Registrar	State of Maryla	nd / Depa		lealth and I		_	06973	
			Decedent's Name (First, Middle, Last)			imouto or i		2. Date of Death	. No. U U U	3. Time of Death	
	Physici			ffen Peise	~			Month	Day Year 10 2005		
	/Medic Examir		4a. Facility Name (If not institution, give s		: L	4b City Town or	Location of Death	February	4c. County of Death	10:00 P ^M	
	Examir	er									
	Eupovali		403 Russell Avenu 5. Social Security Number 6. Sex		. last birthday)	Gaither If Under 1 Year	Sourg If Under 24 Hrs.	Montgomery 9 Birtholage (State or Foreign			
	Funeral Director			M 2□F 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	1917 Gern	place (State or Foreign intry)	
			Usual Residence of Decedent	0,				Aug. 17,	1717 GCIII	iany	
	ylan		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
	Ma-1-8	to	Maryland Montgome	ery	Saither	sburg			1	1XiYes 2 □ No	
	or 28	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What Cou	intry?	
	238 2	a	403 Russell Aven	ue #313		20877		τ	Jnited Sta	tes	
	dea	ne	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Race - Amer		
9	or It	by Funeral	1 ☐ Never Married 2X Married	1 ☐ Yes 2 🗓 No If Yes, Give	I	1 ☐ Yes 2 No	Specify:	o moan, otc.,	Black, White	, etc. h it e	
8	iral',	d b	3 Widowed 4 Divorced	Year or Dates:		163 2010	эрөспу.		Specify: W	III L e	
2	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show ha Madical Examana mast be rediffed at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wor	king 16	b. Kind of Business/In	ndustry	
7	vithin ne. han	ם	Elementary/Secondary (0-12)	College (1-4or 5+)							
,	lled v lygie her t	ပိ	17. Father's Name (First, Middle, Last)	5+	Physi	ical Resea			Federal Go	vernment	
anc	be fi	Be						ne (First, Middle, Ma	iden Sumame)		
<u>~</u>	should be filed vand Mental Hygies markad other tumatic event, In	2	Herbert Peiser				<u>-</u> _	Tarlau			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show arm yinty or other traumatic event, the Medical Evant are routed to contract the contract of the resulting of the contract of the resulting of the contract of the resulting of the contract of the resulting of the contract of the resulting of the resulting of the contract of the resulting of th		19a. Informant's Name/Relationship (Type						city or Town, State, Zi		
	1 and Healt em 2: ther		Primrose Elizabet			ussell Av	e. #313		burg, MD 2		
Ö	ages not of the life of the li		1 ☐ Burial 2 X Cremation 3 ☐ R	emoval from State	cemetery, crer	natory`or other plac		20	c. Location - City or T		
E	tant:		'4 □Donation 5 □Other (Specify)				1	11/2005 A	lexandria,	Virginia	
Baltimore,	permit Depar Impor any in		21. Signature of Euperal Service License	1/1		2. Name and Addres	DC	Vol Funer			
	403#Q		V plad (M)	Seroj					sburg, MD		
H.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease of the death.								
	Pnysician	Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Kidney								Onset and Death 4½ Months	
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
b	Lamino	_	Sequentially list conditions, b								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consa	quente of):						
	and I-trar	xan	that initiated events cresulting in death) Last	Due to (or as a conse	nuence of):			-			
760,	ate be executed hysician and the burial-transit			000 10 (0. 00 0 00.100.	4001100 017.						
∞	The law requires that the death certificate be executed tto has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	dical	d								
9 ×	leath certific attending p	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregn	ancy						
Box	atten for u	lan	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of	aldeath 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year	
P.O.	at the de by the a tached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Jean 5	Other (specify)					
	res that t igned by be detar		Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	nderiving cause give	n in Part I.	23e. Did tobac	co use contribute to t	he cause of death?	
ecords,	sign d be	d by	Coronary Artery Di					1 ☐ Yes	2XINo 3∏Prot	bably 4 Unknown	
ö	w require been sign	ete	Hypertension; Hype								
Rec	sician: The law s certificate has b lirector, page 2 s	Completed						24a. Was an autopsy performe	prior to ca	ppsy findings available impletion of cause of	
<u></u>			Congestive Heart F	Tailure; B-Ce	II Lymp	homa		1 ☐ Yes 24	No 1 ☐ Yes	2□ No	
=	certif	Be	25. Was case referred to medical examiner?	ospital:		_ Othe		th (Check only one)			
o	Phys	2	1 ☐ Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	t 3 DOA	4 ☐ Nursing Hi	ome 5 X Residenc 28d. Describe how	e 6 Other (Special	5/)	
on	ding P. h. After t	To I	1 XNatural 5 ☐ Pending	(Month, Day Year)	Injury	Work	? 'es 2 🗆 No	Log. Bosonbo now	injury occarred		
Division of Vital	Attendi death. ctor: A y the fu	lca	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm str			28f Location (Street	et and Number or Rura	al Poute Number	
2	after Dire	Certification;	4 Homicide determined	building, etc. (Speci	fy)	oot, radiory, dinoc		City or Town, S	itate)	ir riodio ridindor,	
	splta ours neral		29a. Certifier 1X Certifying Phys	sician: To the best of my kn	owledge, death	occurred at the tim	e, date and place	and due to the caus	e(s) and manner as s	tated	
	24 Full	edical	(Check only 2 Medical Examin one)	ner: On the basis of examination and manner stated.	ation and/or inv	estigation, in my op	inion, death occur	red at the time, date	and place, and due to	the cause(s)	
	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certified completely filled in by the funeral director.	Me	29b. Signature and title of certifier		(29c. License	number	29d.	Date signed (Month,	Day, Year)	
)			14. Robert	Dersell	ne a	D 04	4115		February 1	1, 2005	
	17		30. Name and address of person who cou	mpleted cause of death (Ite	m 23a) (The					-	
			H. Robert Birsch	bach, M.D. 2	201 Rus	sell Aven	ue Gait	hersburg.	Maryland	20877	
	Sta	te	31. Date filed (Month, Day, Year) 4 20	32. Agistrar's Signi		serle					
	Registr	ar	FER 1 4 50	DO BROWN.	10. M	APPLAN					

			For State Registrar	State of	f Marylan	•	artment of h	Health and M		giene)5	069	74
			1. Decedent's Name (First, Middle	le, Last)					2. Date of De	ath		3. Time of	Death
	Physici /Medic		CARL	HENDER	SON		PETTUS		Month Februa	ry 9, 2	Year 005	8:20	A M
	Examin		4a. Facility Name (If not institution					or Location of Death		4c. County			
			Suburban Hospit	al			Bethesd	а		Mont	gomer	су	
	Funeral		5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs. I		If Under 1 Year Months Days		8. Date of Birt (Month, Da	v. Yea <i>r</i>)	9. Birthi	place (State o	r Foreign
	Director		578.05.8398	123 M 2LIF		88 Yrs.			June 4	, 1912	Nort	h Caro	lina
	and * -		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Lo	cation					10d. Inside Cit	n/ Limite
	Aarylan I show	5										1 ☐ Yes	
	28a-	Funeral Director	Maryland Monts 10e. Street and Number	gomery	Sil	ver Sp	10f. Zip Code			10g. Citizen of	M/hat Cou		
	with of a	<u>=</u>		1 "105 4								riu y r	
	ns 23	era	531 Randolph Ro	12. Was Dece	dent Ever.in U.S	S. 13. V	20904		acify Yas or No	U.S.A		can Indian.	
(0	r iter	ᇤ	1 ☐ Never Married 2 ☑ Mar	ned 1 137Yes	ident Ever in U.: rces? 6/19: 2 □ No	42	Yes, specify Cub	Hispanic Origin? (Spo an, Mexican, Puerto	Rican, etc.)	Bla	ck, White,		
93	nurs after death with the Man el', or items 23e or 28e 1 sh Exantinet minet be notified		3 ☐ Widowed 4 ☐ Divorced	If Yas Giv	е		I□Yes 2⊠ No	Specify:		Specif	y: Whi	te	
9-0		Completed by	15. Deceder	nt's Education st grade completed)	12/17	16a, Deced	tent's Usual Occup	pation during most of work		16b. Kind of B			
21	l within 72 ho iene. r than "netui i'r Medical	nple.	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	DO NOT use retire	during most of work	ing				
7	filed with Hygiene. ther than	ပ်	10th				Entrep	renuer		Re	stura	int	
nd	be filed ital Hyg id other	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle,	Maiden Suman	70)		
<u>8</u>	should be nd Mental marked o	2	William Pettus					Susan Ha					
Maryland 21215-0036	2 sh and ls m		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	g Address (Street	and Number or Rura	al Route Numbe	r, City or Town,	State, Zip	Code)	
	es 1 and 2 should be fi of Health and Mental H I Item 27 is marked oth r other traumatic ever		Martha Y. Petti	ıs / Wife	20h Bi		andolph	Road #127					4
altimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from		ace of Dispo metery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location -	City or To	own, State	
ţ			`4 □Donation 5 □Other (S		For			ato. 02/1					
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc										
	402 e a	-	Nancy A.	Tercan	نبد			Hampshire			pring		
			23a. Part1. Enter the disease, or shock, or boart failure. List	r complications that controls only one cause on e	aused the death ach line.	. Do not ent	er the mode of dyli	ng, such as cardiac o	or respiratory ar	rest,		Approximate Interval Bety Onset and D	veen
	Pnysician	i I	Immediate Cause (Final disease or condition resulting in death)	a. Pneu	monia							Oriset and E	Gain
	/Medical Examiner		resulting at death)	Due to (or as a consequ	ence of):							
الم كح		_	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a consequ	ance off:					_		
80	ed sit	Examine	cause. Enter Underlying Cause (Disease or injury	4 Ede to (or as a consequ	ence or):							
28.	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c	or as a consequ	ence of):							
709	be executed sician and burial-transit	<u>e</u>				,							
4 688	ate hy:	Physician/Medical		d									_
	eath certific attending p	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnar	ncy				23d Da	te of delive	nn.	
Apired P.O. Box	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as i	clar	in the past 12 months?		irth 2 ☐ Fetal ant at time of de		Ectopic pregnance Other (specify)	у			onth	-	ear
0	at the de by the tached	Jysi	1 Yes 2 No 9 Unknown	9□ Unkno	own								
- 1	that	by Pł	Part II. Other significant conditi	ons contributing to de	ath but not resu	lting in the ur	nderlying cause gru	ven in Part I.	23e. Did to	bacco use cont	ribute to t	he cause of de	eath?
S rds,	quires n sign								1 🗆 Y	es 2□No	3 Prot	oably 4 ⊠U	nknown
2rl Record	w requir been si should	ompleted							24a. Was	an 24b.	Were auto	nosy findings a	ıvaılable
کر Re	The tarate has	m C							autop perfor	med?	death?	psy findings a mpletion of ca	use of
ر Vital		Ö	25. Was case referred to medica					26 Blood of Dooth	1 Yes		1 🗌 Yes	2□ No	
× ×		0 8	examiner? 1 ☐ Yes 2 🛣 No	1.1	npatient 2 1		Ott	26. Place of Death ner: 4 Nursing Ho			os (Cossil		
Pettus Carrision of Vital Re	ding Phys h. After this funeral di	T.	27. Manner of Death			28b. Time of	28c. Injui		28d. Describe h			у)	
F P	nding lath. r: After e funer	atio	1 Natural 5 Pendir 2 Accident investi	ng (Mont igation	n, Day Year)	Injury		rk?]Yes 2 □ No					
Pett	or Attsndi after death. Director: A in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 280. Place	of Injury - At ho	me, farm, str	eet, factory, office		28f. Location (S	treet and Numb	er or Rura	d Route Numb	10 <i>r</i> ,
Ö	pital or A burs after leral Direc filled in by	Cert	4 🗔 1101110000	Odildi	ng, etc. (Specify	/		Į.	City or Tow	n, State)			
	e Hospital or Attsnding 24 hours after death. e Funeral Director: After letely filled in by the fune		29a. Certifier 1 Certifyii	ng Physicien: To the Exeminer: On the ba	best of my know	vledge, death	occurred at the til	me, date and place,	and due to the	ause(s) and ma	nner as s	tated.	
	he Hos in 24 h he Fun pletely	edical	one)	ed at the time, o	date and place,	and due to	the cause(s)						
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	'N D			29c. Licens	se number		29d. Date signe			
	3		· Quan	72	~	_	D 37	891		Feb. 10	, 200)5	
	2		30. Name and address of person	leted caus	e of death (Item	23а) (Туре,	Print)						
190			A. Rajvansui, l	M.D. 121	Congre	ssiona	1 Lane #	409, Rock	ville,	Marylan	d 208	352	
	Sta		31. Date filed (Month, Day, Year,	4 2005	egistrar's Signat	7 6	ale						
	Registr	ar	i LU I	~ 5003	MELLON Y	1							

			4 171	artment of Health and Mer	ntal Hygiene	5 06975
	Physici	an	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Ye	3. Time of Death
	/Medic	al	G. ESTHER POLLACK	th Ch. T	02 08 200	
	Examin	er	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring, MD	4c. County of E	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. 1	Date of Birth (Month Day) Year's 2/06/1912	Birthplace (State or Foreign Country) PA
	Director		213-46-8503 1□M 214F 92 Yrs.	Month's Days Hours Min. 1	270671912	PA PA
	iand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	cation		10d. Inside City Limits
	Mary a-f sh	tor	MD Montgomery Silver Sp	ring		1 Yes 2 □ No
	ith the	Jirec	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	·
	s 23a	Funeral Director	713 Whitaker Terr	20901	United St	
320	IN LIFE SOUNS after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Thygiene. The Than Insturel', or Items 23s or 28s-f show only, the Madical Examinant russ the notified at		1 Never Married 2 Married 1 Ves 2 No.	Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica I ☐ Yes 2 No Specify:)	American Indian, Yhite, etc. White
֖֝֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֡֓֡֓֡֓֓֡֓֓֓֡֓֡֓֡֓֡	72 hou	eted by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16b. Kind of Busine	ess/Industry
7	within ne. han "	Be Completed	Elementary/Secondary (U-12) College (1-4or 5+)	kind of work done during most of working OO NOT use retired) unting Technician	Federal	Government
Z	e filed v Il Hygie othar t	Co	17. Father's Name (First, Middle, Last)		irst, Middle, Malden Sumame)	Government
yland	lid be lental rked o	To Be	Charles Glazer	Ida Mintz		
Mary	s mar	_	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	g Address (Street and Number or Rural Ro	oute Number, City or Town, Sta	te, Zip Code)
≦ ~`	and 2 ealth m 27 i			hitaker Terr Silver		
0	Profit		IAL Dullar 2 Cremation 3 Minemoval notes 5 at 5	natory or other place)		
galtimore,	artmer ortant injury		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee	. Name and Address of Facility	2005 Falls Cil	uren, va
ä	permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked otheny injury or other traumatic event ance.			1800 New Hampshire	Ava Silver Spr	ing MD 2090/
			23a. Rart1. Enter the disease, or complications that caused the death. Do not en shack, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Kidney Failure			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): Pyelonephritis			
l.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	outed ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c			
Š	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
09/89	icate b physic s the b	dical	d			
O. Box	the death certificate be executed y the attending physician and ached for use as the burial-transit	Physician/Me		Ectopic pregnancy Other (s <i>pecify</i>)	23d. Date of Month	delivery Day Year
J.	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death?
	w requires that been signed b should be deta	ed b	Hypertension		1 ☐ Yes 2 No 3 ☐	Probably 4 Unknown
Vital Records,	siclan: The law re certificate has be irector, page 2 sho	Completed			autopsy prior performed? deatl	
<u>ra</u>	lan: ortifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Ca		765 Z NO
0 0	Physic this ce al dire	ို	1 ☐ Yes 2 🛣 No Hospital: 1 🛣 Inpatient 2 ☐ ER/Outpatien		5 Residence 6 Other (S	Specify)
	ding P h. After i funera	tlon:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation 2 ☐ Accident	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred	
UIVISION	f or Attanding Physiclan: after death. Diractor: After this certifica in by the funeral director, i	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		Location (Street and Number of	Rural Route Number,
5	tal or	Certification:	4 Homicide Stemmed building, etc. (Specify)		City or Town, State)	
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat construction on the death of the	occurred at the time, date and place, and restigation, in my opinion, death occurred a	due to the cause(s) and manner at the time, date and place, and	r as stated. due to the cause(s)
	To tha within 2. To tha i	2	29b. Signature and title of certifier	29c. License number D0071768	29d. Date signed (M 02/08/200	
	25		Fairence & Jonald M.	<u> </u>	02,00,200	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Fabieene G. Santel, MD 1500 Forest G.	en Silver Spring. M	Œ	
	6 Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	uli		
	Registr	ar	FEB 1 4 2005 Brew B. A.			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year В William Dewayne Parks February 9, 2005 8:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6963 Walston Switch Rd. Salisbury Wicomico If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours Min. 1**X** M 2□ F Months Director <u>218-48-5596</u> 58 11/26/1946 Delaware Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County r than "netural", or Items 23e or 28a-f show It e Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6963 Walston Switch Rd. 21804 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Driver Produce Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is markad oth any injury or other traumetic event QRRg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Parks Betty Irene Foskey ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Twila Lee Parks/wife 6963 Walston Switch Rd., Salisbury ND 21304 e of Disposition (Name of Date 20c. Location City or Town, Sta 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory February 10,2005 Salisbury, MD nature of Funeral Service Liven ee 22. Name and Address of Facility Holloway Funeral Home Professional Association 29a. Part. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

A 29a. Part. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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A 29a. Part. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 Lemos nostar /Medical Due to (or as a consequence of) Examiner M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner OPD requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. detached been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Tes 2 🗆 No 3 No 1 Yes Hospital or Attanding Physician: 24 hours after death. director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending М 1 Tes 2 No 2 Accident investigation Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To tha Hospital of within 24 hours at To tha Funaral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature-and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0061 meu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elleda Ziemer 100 Power St. Salisbury, MD 21801 410-543-2051 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 1 2005 Registrar

		1 _ State	State of Maryla	•	artment of H		_		
Physici	an	Registrar 1. Decedent's Name (First, Middle, Last)			inodic or i	Joann	2. Date of Death Month	Day Yeer	3. Time of peagh
/Medi Examir	cal	Lois Faye 4a. Facility Name (If not institution, give st	reet and number)	rice		Location of Death	2	4c. County of Deat	8:10 PM
Funeral Director		Atlantic General F 5. Social Security Number 6. Sex 237-66-0514		s. last birthday) Yrs.	Berlin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y	'ear) Co	r hplace (State or Foreign ountry) n Carolina
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Delaware Sussex		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
72 hours after death with the Maryland *natural*, or Itams 23e or 28e-f ehow Alcel Exercities reset to redition at	Funeral Director	10e. Street and Number #6 Wanmar Lake	2. Was Decedent Ever in Armed Forces? 1 □ Yes 2 (X)No	U.S. 13.	10f. Zip Code 1997 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ame Black, Whit	ncan Indian,
72 hours a 'natural', o	eted by	3 XWidowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	If Yes, Give Year or Dates: ation completed)	16a. Deced	1 ☐ Yes 2 X No dent's Usual Occupation of work done of	turina most of worki	ing 16	Specify: Williams Specify: Wil	Thite Industry
	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5+	life. I	SSOR Of B)	М		on College
	To Be	Horace Ephriam 19a. Informant's Name/Relationship (Typ	Perry, (ng Address (Street a	Faye	Euncie	Weathe	
		Marsha Renfrow (con 20a. Method of Disposition 1 & Burial 2 Cremation 3 Re	20b.	Place of Dispo	nmar Lake sition (Name of matory or other place			aware 199	
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser	Ro	ff	olloway f	uneral Ho	ome Profe	ssional As	e, North Caroli ssociation and 21804
Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line. Due to (or as a conse	ath. Do not ent					Approximate Interval Between Onset and Death
A.F.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		rdio my	ope/hy			3 gens
eath certific attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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Physician: The string of this certificate and director, page	To Be	27. Man of Death	ospital: 1 Inpatient 2[28a. Date of Injury (Month, Day Yeer)	28b. Time of	t 3 DOA Othe	26. Place of Death ar: 4 Nursing Hor		ce 6 □Other (Specinjury occurred	sify)
or Attending Ph ter death. irector: After th n by the funeral	Certification:	27. Man of Death 1. Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 1 Yes 2 No 28b. Time of Injury at Work? 1 Yes 2 No 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Location (Street and Numic City or Town, State)						et and Number or Ru State)	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical Cer	29a. Certifier 1 Certifying Physi (Check only one)	cian: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death	n occurred at the tim vestigation, in my op	ee, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as	stated. to the cause(s)
To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	17	4 SICTO	29c. License			Date signed (Month	
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aryla	shoy	_	10a. State 10b. County		10c. City, To		ation					10d. Inside City Limits 1 ☐ Yes ※XXNo
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S as	al', o	b	3∰Widowed 4 □ Divorced	If Yes, Give Year or Dates	i:	1	☐Yes 2∭XNo	Specify:			Specify: W	hite
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Danti. Permit. Permit. Permit.	Importent: If item 27 is marked other than "natural", or liems 23a or 28a-1 show any injury or other treumatic event. It medical Exantiner must be notified at ones.		21. Signature of Funeral Service Lie		, Incour		Name and Addres	ss of Facility	Stauf	fer Fur	neral Ho	mes, P.A.
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:15/1 Carmen Procaccino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⅓**M 2□F Months Yrs. Director Nov. 24, 1926 Italy 578-40-2596 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits יטרולים אות בעול המשברים והמידים אות and than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Erain an must be multipled at se. 1 ☐ Yes 2 No Director Maryland Prince George's <u>Hyattsville</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20783 2419 Hannon Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 弦Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 21X Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Bakery Supervisor Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi Pasquale Procaccino Teresa Tenore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 is any injury or other training. Emilia Procaccino Wife 2419 Hannon Street Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ³ 4 □ Donation 5 □ Other (Specify) Feb. 15, 2005 Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lief only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician na ay disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner 2 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 2 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 08 101 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane #222 Bowie, Maryland 20715 Rakesh Arora, M.D. 1 5 2005 State Registrar

CLINTON

MD-20735

1-	For State Registrar

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Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 2:15 P M William O. Powell February 9, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Center Clinton If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**⊠**M 2□F 227-12-7408 82 1922 North Carolina Director May 3, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show rutified at 1 ☐ Yes 2 No MD Prince Georges Upper Marlboro Direct the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or 6210 Buttercup Lane 20772 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or item migoriant: in the Medical Examinations." MXYes 2□No Il Yes, Give Korean Year or Dates:Conflict 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Be William Andrew Powell Martha Clarke Evans ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrtle I. Landreth/Sister 502 Burnt Mills Avenue, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2005 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition erebrovascular disease Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-fran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed ate 1 Yes 2 No Hospital or Attending Physicien: certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification; To this funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Natural 5 Pending 1 Yes within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

31. Date liled (Month, Day, Year) 1 5 2005

unan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title o



MD

DHMH 17 Rev 1/2001

D0052999

			1 - For Stete Registrar	State of Ma	ıryland	•	artment of H		d Mental Hyg	giene No. 2	005	069	181
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Katherine		Elise	PACE			2. Date of Dea Month February	Day 11,		3. Time of De 1:15p	eath M
C.	Examin	er	4a. Facility Name (If not institution, give s Avalon Manor 5. Social Security Number 6. Sex		(In vrs. la	ast birthday)	4b. City, Town, or Hagers			Wa	ashing	ton	Foreign
	Funeral Director		086-20-0121 1□ Usual Residence of Decedent	M 2⊠ F	8	33 Yrs.	Months Days		June 20	, 1921	1 New	York	
	he Marylar 28e-f show ciilisd al	ector	10a. State Maryland 10b. County Washingt	on		Town or Lo	vn			- 011		1 Yes 2	
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other treumetic event, it e Medical Examiner must be notified at 90ce.	by Funeral Director	13301 Hunter Hill	Drive Ap	ot D Everin U.S	6. 13. <u>\</u>	10f. Zip Code 2174 Was Decedent of His		? (Specify Yes or No- uerto Rican, etc.)	U.S.	Race - Americ	can Indian,	
0036	hours after turel', or ite		1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 15. Decedent's Educ	1 Yes 2 N If Yes, Give Year or Dates:	10		1 □ Yes 2 ☒ No	Specify:	derto nican, etc.)	Spe	Black, White,	ite	
21215-0036	d within 72 giene. er than "na'	Completed	(Specify only highest grade Elementary/Secondary (0-12) 0-12	College (1-4or 5-	+)	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired cal Techn	furing most of)	working		f Business/Ind	ĺ	
Maryland	ould be file Mental Hy varked other vatic event.	To Be (17. Father's Name (First, Middle, Last) Robert	Craft	: Но	use			Name (First, Middle, Minna	And	lersen		
re, Mar	1 and 2 sh Health and tem 27 is n		19a. Informant's Name/Relationship (Type Hollomon-Brown Fune 20a. Method of Disposition		20b. Pla	1457	Independ	ence B	Rural Route Number Lvd., Virg	inia I		VA 234.	55
Baltimore,	mit. Pages partment of sortent: If i / injury or e		1 ☐ Burial 2 ☐ Cremation 3 ☑ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			dlawn	natory or other place Mem.Garde . Name and Addres	ens 2/	25/05 MINNICH		Norfol	**	
Ä	Per min gr		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused e cause on each lin	the death.				lvd., Hage	erstow		yland 2 Approximate Interval Between	en
	Medical Examiner with prize the prize transit the prize transit the prize transit tran	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lary leading to intraction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	ence of		w, 11	n mit	astes	15	Onset and Dea	iti
P.O. Box 68760,	death certific e attending p od for use as	Physician/Medical I	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy			1	Date of delive Month	ory Day Yea	lr
	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions conf	tributing to death bu	t not resul	lting in the ur	nderlying cause give	n in Part I.		bacco use co es 2 □ No		e cause of deal	
al Reco		Completed				-			24a. Was a autops perform	ned?	b. Were autop prior to con death? 1 Yes	psy findings ava npletion of caus 2 No	ulable se of
Division of Vital Records,	To the Hospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	27. Mannarof Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	ospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day	Year)	R/Outpatien 28b. Time of Injury ne, farm, stre	28c. Injury Work M 1 🗆 Y	r: 4 Nursin	Death (Check only on g Home 5 Reside 28d. Describe ho	ence 6 Co	curred		r,
Ö	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Medical Cert	29a. Certifier 1 Certifying Physic (Check only 2 Medicel Examin	er: On the basis of	f my know examinati	rledge, death	occurred at the tim	e, date and pl	ace, and due to the ca	ause(s) and	manner as st	ated.	
)	To the within 2 To the comple	Med	7	and manner stat				0 60	396	9d. Date sign	ned (Month, E	Day, Year)	
15:	H-5	to	30. Name and address of person who core PATALD MURS	HEDI	10		1.1	010		mn	21"	740	
	Registr		31. Date filed (Motor Pay, 293) 200	32 Aegistra	- 1	· pp	uke						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

ORIGINAL

Physi /Med Exam

Funera Directo

Physician /Medica **Examine** To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ın al	Registrar	Cei	rtificate of Death		Reg. No	1000	
	1. Decedent's Name (First, Middle, Last)			Mon		U (Vear)	3. Time of Death
		RSONS		FEBI	RUARY	7 2005	11:00a ^M
	4a. Facility Name (If not institution, give street and r	number)	4b. City, Town, or Location	of Death	4c. C	County of Death	1
	10263 Worton Rd.		Chestertow		Ke	ent	
	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	Min (Mon	th Day Year)	9. Birth	nplace (State or Foreign untry)
-	220-34-7553	8.2 Yrs.		Sept	4 192	22 Ma	rýland
-	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	antion				10d. Inside City Limits
	·						1 ☐ Yes 2X No
2 -	MD Kent	Chester					
5	10e. Street and Number		10f. Zip Code			en of What Col	untry?
a L	10263 Worton Rd.		21620		U.5	5.A.	
Funeral Director		cedent Ever in U.S. 13. \ Forces?	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexical	igin? (Specify Yes n, Puerto Rican, et	or No- 14	 Race - Amer Black, White 	
Dy F.	If Yes. 0	s 2⊠No Give	1 ☐ Yes 2 ☑ No Specify:	:		Specify: W	hite
3 -	3 ☐ Widowed 4 ☐ Divorced Year or	Dates:					
210	15. Decedent's Education (Specify only highest grade completed	d) (Give	dent's Usual Occupation kind of work done during mos	st of working	16b. Kin	d of Business/I	ndustry
Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	DO NOT use retired)				
5	12	Owne	r - Operato			arm	
ם ב	17. Father's Name (First, Middle, Last)			er's Name (First, A		iumame)	
2	Louis Barrett Parso	ons	Mar	y Mille	er		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number	er or Rural Route i	Number, City or	Town, State, Z.	ip Code)
	<u>Stephanie Clayton (</u>			Lane (Centrev	/ille,	MD. 216
-1	20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Loc	ation - City or T	Town, State
	1 🛱 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)		Cemetery	2/12/0	5 Che	estert	own, MD.
	21. Signature of Funeral Service Lizensee		Name and Address of Facility Alena Funera				
	120	M00510 13	8 West Cros	al Home	OI Ste	epnen	21635
	2 a. Pant. Enter the disease, or complications tha	t caused the death. Do not ente	er the mode of dying, such as	cardiac or respira	tory arrest,	, MD.	Approximate
	Immediate Cause (Final	n each line.					Interval Between Onset and Death
	disease or condition a. P	neumonia					days
	Due t	o (or as a consequence of):					
	Sequentially list conditions, b.	o (or as a consequence of):					
É	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence or).					
Examine	that initiated events c.	o (or as a consequence of):				-	
		. (4	
n/Medical	d						
Me	IF FEMALE:	udaama af arangana.					
an	in the past 12 months?	outcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy		23	3d. Date of delive Month	very Day Year
	1 ☐ Yes 2 ☐ No	gnant at time of death 5∟	Other (specify)				,
2	9 Unknown				Didaster	a analysis s	the court of d = 1.0
rnysic	But the Calculation of the Control o	death but and a feet of the	and a decide the management of the contract of		. DIO TODACCO US	e contribute to	the cause of death?
by Physic	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause given in Part I	, 236			
Ď	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause given in Part I		1 ☐ Yes 2 🛣	No 3□Pro	bably 4 Unknown
2	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause given in Part I		Wasan	24b. Were aut	opsy findings available
2	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause given in Part I	24a.	Was an autopsy performed?	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
Completed by		death but not resulting in the ur		24a.	Was an autopsy performed?	24b. Were aut	opsy findings available ompletion of cause of
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to be completed by	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1] Inpatient 2 ☐ ER/Outpatien	26. Place t 3 DOA Other: 4 No	24a. 1 □ a of Death (Check ursing Home 5 🕱	Was an autopsy performed? Yes 2 12 No only one)	24b. Were aut prior to codeath? 1 Yes	opsy findings available ompletion of cause of
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			_ For	State of Ma	arylan	d / Depa	artment	of He	ealth a	nd Me	ental Hy	giene	Logibio	•	
			1 - State Registrar			Cei	rtificate	of D	eath			Reg. No	200	$\bar{0}$	6984
	Physic	an	Decedent's Name (First, Middle, La	ist)						2	2. Date of De. Month	ath Day	Yea		Time of Death
	/Medi	cal	Anna Louis 4a. Facility Name (If not institution, gin	e Pearce			4b. City. T	own, or I	ocation of	Death	02,		2005 County of D		1:31a [™]
Н	Examir	ier	Union Hospit	_				cton		004			ecil	54 11	
	Funeral		Social Security Number 6.3			ast birthday)	If Under 1		If Under 2 Hours	4 Hrs. 8	3. Date of Birt (Month, Da			Birthplace Country)	(State or Foreign
	Director		221 – 16 – 3794 Usual Residence of Decedent	- X	7	7 Yrs.					06/28,			_DE	
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Ir	nside City Limits
	Ba-fs	ctor	MD Ceci	l	(Cecil	ton							1	☐ Yes 2 ☑ No
	with th	Dire	10e. Street and Number 575 Cecilton	Vancoi als D			10f. Zip (913			10g. Citi	zen of What	Country?	
	ns 23	eral	11. Marital Status	12. Was Decedent I		S. 13. \	Was Decede			in? (Spec	ify Yes or No- ican, etc.)		USA 14. Race - A		dian,
9	after or Iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 N If Yes, Give	40		lfYes,specif 1⊡Yes 2		, Mexican, Specify:	Puerto Ri	ican, etc.)		Black, W		
8	be filed within 72 hours after death with the Maryland hal Hygiene. ad other then "naturel", or Items 23a or 28a-f show event, the Medical Exerth at mat be routified at	Completed by Funeral Director	3 ₩idowed 4 Divorced	Year or Dates:								10: 10:			asian
21215-0036	in 72 n "nat	piete	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual kind of work DO NOT use	done du retired)	iring most	of working	7	160. KI	nd of Busine	ss/industry	,
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5)+)	wa	aitre	ss_				re	stauı	cant	
	be filed that Hygis and other event, I	Be	17. Father's Name (First, Middle, Last					1			First, Middle,				
Za	should to d Ment marks	은	Wesley Rey	ynolds		10b Mailin	a Addross ((Stroot or			ha Bu			Zin Code	
Maryland	id 2 st th and 27 is r		Jackie Virdi		r						k Rd.				-
	s 1 ar of Hea item (20a. Method of Disposition		20b. Pl	ace of Dispo emetery, cren				Da	-		cation - City		
Ē	Page nent c ent: If ury or		1 ☐ 8urial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	JRemoval from State fy)	1					2/10	/2005	Ce	cilto	n. I	AD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic er once.		21. Signatur /o Funeral Service Lice	71 1 1		22	. Name and	Address	of Facility						ral Hom
*	70 = # Q	-	23a. Part1. Enter the disease, or comshock, or hear failure. List only	Illians that caused	the death	Do not ente	70 W.	of dving	pres	s St	Mil	lin	gton,	MD	21651
	Observatoria		shock, or hear failure. List only Immediate Cause (Final	one cause on each lin	10.	.01			7	1				Inter	rval Between et and Death
ı	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequ		INFR	TVLL	11 Or	<u> </u>				1722	NZS
ı	Examiner		Sequentially list conditions	. ASCV	0									Ve	HVZ
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):									
	te be executed ysician and e burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a	a consequ	ience of):								-	
760,	ate be executed hysician and the burial-transit	cal		d											
89	artifica ing ph	Medi	IF FEMALE:				<u> </u>								
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4☐ Pregnant at	2 🗌 Fetal	death 3	Ectopic pred					2	3d. Date of one Month	lelivery Day	Year
o.	the de y the g	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	title of de	,aiii 5_	J Cities (spec	Cily)							
<u>α</u>	Attending Physicien: The law requires that the death certifica relation. I cleath. ector: Affer this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	by Physician/Med	Part II. Other significant conditions	-	ut not resu	Iting in the ur	nderlying cau	use given	in Part I.		23e. Did to	bacco u	se contribute	to the cau	use of death?
ğ	w require been sig should b		HYPEYZIEN	1510N							1 🗆 Y	es 2	□No 3□	Probably	4 Monknown
ecc	e law r has be je 2 sh	Completed	DIABETE	2						_	24a. Was autop	sy	24b. Were prior to death	o completii	ndings available on of cause of
<u>e</u>	lcien: The certificate l rector, pag											2 No	1 □ Y		40
Division of Vital Records,	ding Physicien: The larh. h. After this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2	R/Outpatien	t 3 DOA	Other			Check only on 5 ☐ Resid		Other (S	necify)	
סנ	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injur (Month, Day	v	28b. Time of Injury		c. Injury a Work?		-	d. Describe h			,7	
Sior	endin eath. or: Af	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n			М	1 □ Ye	s 2 🗆 No						
.≝	or Att	Certification:	3 Suicide 6 Could not be determined		ry - At ho c. (Specify	me, farm, stre	eet, factory,	office		28	1. Location (S City or Tow			Ru <i>ral R</i> out	e Number,
_	To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the		29a. Certifier 1 Certifying Pl	nysician: To the best of	of my know	vledge, death	occurred at	t the time	, date and	place, an	d due to the o	ause(s)	and manner	as stated.	
	n 24 h	edicai	(Check only 2 Medical Exa	niner: On the basis of and manner sta	examinat	ion and/or inv	estigation, in	n my opir	nion, death	occurred	at the time, o	date and	place, and d	ue to the c	ause(s)
	To ti To ti com	Ž	29b. Signature and title of certifier	Splin	LAY	$\overline{}$		License r		7			signed (Mo	-	
			- aura	- CKW	NII			200	31.	5	ľ	eb	van	101	2005
		1	30. Name and address of person who Laura Ellis, N					MD 2	1921				_		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra		ure			1741						
	Regist	ar	CCD A	8 2005	AR AR	· M	Anta	10							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Year

POLAND

Black, White, etc.

FURS

Month

FINERMAN

WHITE

12:01 P^M

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

Approximate Interval Between Onset and Death

Year

Day

3 Probably 4 Unknown

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician FEBRUARY 8, 2005 DAVID RUBIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1801 EAST JEFFERSON STREET ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Yrs. **Director** 174-26-5642 87 DEC 11, 1917 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic avant, the Medical Examinating Exprofiled at once. 10a. State MARYLAND MONTGOMERY ROCKVILLE Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20852 1801 E. JEFFERSON STREET UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 FURRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ပ BARUCH YENTEL 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3173 PORTER ST, NW RUTH RUBIN FADEN, DAUGHTER WASHINGTON, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Other (Specify) 4 Donation KING DAVID MEM. GDN. 2/10/2005 FALLS CHURCH, VA 21. Signature of Funeral Service Lice see DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Jake 1170 ROCKVILLE PIKE, ROCKVILLE, MD 122 23a. Part1. Enfer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC GASTRIC ADENOCARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe DIABETES TYPE II 2 XNo 1 Yes Completed been CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 2 X No 1 Yes To the Hospital or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending 1 X Natural investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D11/040 D0057884 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMIEN J. DOYLE, M.D., 1801 E. JEFFERSON STREET, ROCKVILLE, MD 31. Date filed (Month, Da Day, Year

2005 20852 32 Registrar's Signature

State

14

		Ľ	1 - For State Registrar	State of Marylar		artment o			d Mental Hy	giene	05	06096
	Physici		Decedent's Name (First, Middle, Las CTEVET AND DOD	,					2. Date of De Month	Day	Year 2005	3. Time of Death
	/Medi Examir		CLEVELAND ROB 4a. Facility Name (If not institution, give			4b. City, To	wn, or Loc	cation of D	FEB.	4c. County		2;53 A [™]
			PRINCE GEORG			CHEV			dro I			EORGE
ı	Funeral Director		579-26-6894	7. Age (In yrs.	Yrs.	If Under 1 Months		Under 24 I lours N	lin. (Month, Da	rth ay, Year) 22,1925	Count	ace (State or Foreign ry) DEN SC
	show		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10	d. Inside City Limits
	the M	Director	MD PRINCE	GEORGE CA	PITAL	HEIGH 101. Zip Co				10g. Citizen of V	Vhat Count	1 ☐XYes 2 ☐ No
	23a or		3814 DENT ST	REET			743			USA	viiai Oodiii	•••
	ter deat	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deceden	t of Hispan	nic Origin?	(Specify Yes or No Jerto Rican, etc.)	o- 14. Race	e - America k, White, e	
36	irs afte	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2 ☐		pecify:	,		BLAC	
21215-0036	72 hours "natural", idical Ex-		15. Decedent's Ed (Specify only highest grad	ucation	16a, Dece	ient's Usual (Occupation	n na most of	working	16b. Kind of Bu	ısinəss/Ind	ustry
121	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use i	retired)	•	-			
	filed v Hygie othar t		17. Father's Name (First, Middle, Last)		HEAV	Y EQU.			RIVER Name (First, Middle	TRANSP		TION
/lan	uid be Aental rked c	To Be	JOSEPH ROBIN	SON			M.	ARY	RICHARD	S		
Maryland	12 should be filed within 'n and Mental Hygiene.' 7 Ia marked othar than "r raumatic evant, the Med		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (S	treet and	Number o	Rural Route Numb	er, City or Town,	State, Zip (Code)
	os 1 and 3 of Health itam 27 other tra		EVELYN B. ROBIN		3814	DENT		· CA	PITOL HE	20c. Location -		
mor	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crer	natory or othe	r place)	rery	2/19/05			
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licens	S99		. Name and A			CEDAR HI			
8	20 E 20		Mary Hedgin	m MD1374	4:	111 Pe	enns	ylva	nia Ave	. Suitl	and	MD 20746
ı			23a. Part1. Enter tile disease, or comp shock, or heart failure. List only o Immediate Cause (Final	one cause on each line.		er the mode o	of dying, su	uch as care	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq	110000 of):	yndr	ens					DAYS
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8760	ate be hysicia he bur	dicai		d								· · · · · · · · · · · · · · · · · · ·
9	eath certifice attending pl	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ncv							
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Records,	w requ been shouk	ompleted	R	6- Fa :0:	_0	·			24a. Was			sy findings available
Re	The law ate has page 2 (ошо	- Indifue	134 / 20					- autor	psy p ormed? d	rior to com eath?	pletion of cause of
/ital		Be C	25. Was case referred to medical examiner?				26.	Place of I	Death (Check only o			
Division of Vital	Physiclan: r this certificated ral director,	ဥ	1 Yes 20 No 27. Manner of Death		ER/Outpatien		Other: 4	↓ □ Nursin	g Home 5 Resi	dence 6 Othe		
ion	nding th. : After s funer	ation	1 Natural 5 Pending 2 Accident investigation	28a, Dote of Injury (Month, Day Year)	Injury	М	Work?	2 🗆 No	200. Describe	now injury occurre	90	
ivisi	r Attar er dea ractor	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, o	ffice		28f. Location (. City or Tox	Street and Numbe wn, State)	or or Rural	Route Number,
	pltal o urs aft aral Di		20.0.11									
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funeral Diractor: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the occurred at th	my opinio	ate and plant, death o	ace, and due to the courred at the time,	cause(s) and mar date and place, a	nner as stai nd due to t	ted. he cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	0 1		1	icense nur			29d. Date signed		ay, Year)
)	(* Micha	el-figuros		5	005	5286	.5	Februar	ing	15 72005
R	(10)		30. Name and address of person who	plet d cause of death (Item	23a) (Type.	MIChae	1 K	igar	7		/	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture of	MICHAL		9000	-			
	Regist	ar	FEB 1 6 2005	Blake #	Angel							

			1 For State Registrar	State of N	/laryland		artmen				lental Hy	giene Reg. No.?	2005	0.000
	Physici	an	1. Decedent's Name (First, Middle, Last	")	-						2. Date of De		Year	3: Time of Death
	/Medi	al	Agnes Bernice 4a. Facility Name (If not institution, give				4h Cih.	Tau	1ti		Februa		,2005	3:30am M
	Examir	er	3229 Walters Lan		r)				Location o	of Death			County of Death	
	Funeral		5. Social Security Number 6. Se		Age (In yrs. Ia	ast birthday)	Fore If Under	1 Year	If Under		8. Date of Bir	th	rince (place (State or Foreign
L	Director		577-84-3564	□M 2 X X	58	Yrs.	Months	Days	Hours	Min.	(Month, Da Nov 1			intry) Ington, VA
	and w		Usual Residence of Decedent 10a. State 10b. County			. Town or Lo	cation							10d. Inside City Limits
	Manyli sho	ō	MD Prince G	000000		estvi								YSYes 2 □ No
	r 28e	Director	10e. Street and Number	eorges	FOL	estvi	10f. Zip	Code				10g. Citize	en of What Cou	intry?
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	r dea	Funeral	11. Marital Status	12. Was Deceder Armed Forces			Was Deced	ent of His	panic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		Race - Amer Black, White	ican Indian,
36	within 72 hours after death with the Maryland ene. than "natural; or Items 23a or 28e-f show he dicel Evani net must be notified at	by Fu	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2v If Yes, Give Year or Dates	X ^N o		1 ☐ Yes 2		Specify:			s	Specify: Bla	
21215-0036	2 hour		15. Decedent's Edu		·	16a. Deced	ient's Usua	I Occupa	tion			16b. Kind	d of Business/li	adustry
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ē,			20a. Method of Disposition		0.00	ace of Dispormetery, crem	sition (Nam	e of		#1-	Z Fores	20c. Loca	Le,MD 2 ation - City or T	0/4/ own, State
E	Page: ient o nt: If iry or		1 X Burial 2 □ Cremation 3 □ F 14 □ Donation 5 □ Other (Specify)		B	hingto		,	* i	m 2-	19-05	Suit	tland,M	D
Baltimore, Maryland	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licens	98 M. O.	1						Funera			
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			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that cause ne cause on each	ed the death. line.	Do not ente	or the mode	of dying	, such as	cardiac o	r respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	4	AN CAI									Onset and Death
	Examiner			Due to (or a	s a conseque	ence of):								
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseque	ence of):								
	cuted	Examiner	cause. Enter Underlying Cause (Disease or Figury that initiated events											
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9 xo	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcom	e of pregnan	cv						-	4 8-1	
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g	w require been si should b	ted									1 🗆 Y	es 2 X	No 3 ☐ Prob	ably 4 Unknown
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		Con										med? 2□√No	death? 1 🗌 Yes	
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	Phys r this ral di): To	1 XYes 2 No	28a. Date of Ini	urv 2	R/Outpatient 8b. Time of		c. Injury	4 🗀 1901		ne 5 Resid		Other (Specif	y)
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Division of	Attendi ar death. actor: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	ijury - At hom tc. (Specify)	e, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	treet and A	lumber or Rura	l Route Number,
ā	ital or rs afte el Dli	Cert		-										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the besi ner: On the basis of and manner s	or examinatio	edge, death n and/or inv	occurred a estigation, i	t the time n my opii	, date and nion, death	l place, a n occurre	nd due to the c d at the time, c	ause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier	and marrier s	iateu.		29c.	License	number		- 2	29d. Date s	igned (Month,	Day, Year)
			Mahuk	Hus	saì			IOOEC	OFO			Febr	uary 16	5,2005
-	(6)	-	30. Name and address of person who co	-	•		rint)	10060				CDL	aury 10	12003
			Mahrukh Hussain M	1.D. 122]	Merca	antile	Lane	,Lar	go, MI	20	774			
	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 6 2005	2. Regist	rar's Signatu	Land	8,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0953 Februar 13 2005 Michael Jay Raynor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sal/ eninsula egional Medical Center WICOMICO 5001 If Under 24 Hrs. Funeral 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birth place (State or Foreign Country) Min. Days 1**X**M 2□F Months Hours Director 49 219-62-8191 April 30, 1955 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25424 Porter Mill Road 21830 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. withIn 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) e tited with! al Hygisne. I other than 12 Diesel Mechanic Alban Tractor Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I Ronald Holmes ဂ္ Raynor Irene Bernice Whayland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a, Important: If item 27 is any Injury or other trau 25424 Porter Mill Road, Hebron, Maryland 21830 Constance Lynn Raynor (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State (4 □ Donation 5 □ Other (Specify) Springhill Memory Cardens February 19, 2005 Hebron, Maryland nature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland Approximate Interval Between Onset and Death 231. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de ?? þ page 2 should b 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an rmed? certificete 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 1 Yes 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760 Hospitel or Attending Physician: 24 hours e e Funerel (

Medical within 2 To the To the Registrar

4 - Homicide

(Check only one)

29b. Signature and title of cert

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snyder D.O. 1008ast CanallStreet Stisbury mel 21801 neistochen 31. Date filed (MortE By, 1ea/6 2005

and manner stated.

2 Medicel Exemina

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

450497

29d. Date signed (Month, Day, Year)

2/16/05

				State of Mary				_	_	ibie.	
			1 - State Registrar	,		ertificate of		_	Reg. No	05	00000
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give st	m 5Cy reet and rlumber)		4b. City, Town, o	or Location of Death	4	4c. Count	y of Death	1025 M
44	LAGIIII	ići	Coastal Hospice o	(11)	ke	Salish		. 21801	Wic	omi	CO
	uneral		5. Social Security Number 6. Sex		yrs. last birthda Yrs	Months Days	Hours Min.	8. Date of Bird (Month, Da 7/24/19	th y, Year) 37	Coun	
	irector		Usual Residence of Decedent					//24/1			xas
arylan	show	r.	10a. State 10b. County		City, Town or					1	0d. Inside City Limits 1 XYes 2 □ No
the M	r 28a-f	Director	Maryland Wicomico		Salish	10f. Zip Code			10g. Citizen of	What Coun	ntry?
death with the Maryland	d other than "natural", or Itams 23a or 28a-f show event, the Madical Exeminer must be notified at	al Di	1007 Riverside Dr	ive		2180	01		USA		
	Itams Fer 1	Funeral	11. Wanta States	2. Was Decedent Ever Armed Forces?	in U.S. 1	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americ ack, White,	
7215-0036 within 72 hours after	al' or	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ZVes 2 NoN If Yes, Give Year or Dates: WW	avy II	1 ☐ Yes 2 ☒ No	Specify:		Speci	fy: wh	ite
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within	than the M	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		ations Off			Centra Agenc		telligence
nd 2	othar vant,	BeC	17. Father's Name (First, Middle, Last)	_	Oper	actoris of	18. Mother's Nam	e (First, Middle,			
Maryland 212 d 2 should be filed within		2	Earl Ramsel	- 6-/	405 14	W - Add (Co		ne Lever		O4- 4- 70-	0-4-1
Magar Ma Magar Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma	itam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type Joann L. Ramsey/wif	•		iling Address (Street 7 Riversio			-		Code)
or Hear	itam r otha		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	movel from State	b. Place of Dis	position (Name of rematory or other place	ce)	Date	20c. Location	- City or To	own, State
Pag Pag	tant: If i		' 4 □ Donation 5 □ Other (Specify)		alisbu	cy Cremato			Salisb		
Balti permit. Deporter	Important: If is any injury or o		21 Signature of Funeral Service Licenses			22. Name and Addre	Funeral F	lome Pro	ofessio	nal As	ssociation
direction.	27/23	P 17 14	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one		death. Do not	501 Snow enter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	2.2180	Approximate
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		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	ARY sequence of):	ARTE	4 21	ZSRA	SE		YIMI
cuted	nd Iransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
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The dear TH	by the at tached fo	yslci	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death	Other (specify)			141	omm	Day Teal
that	igned by be detac	y Ph	Part II. Other significant conditions cont	ributing to death but no	resulting in the	underlying cause giv	ren in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?
Hecords, he law requires t	been sig should be							1 🗆 Y	res 2 XNo	3 Prob	ably 4 □Unknown
e law r	9 01	Completed						24a. Was autop		Were autor prior to con death?	psy findings available npletion of cause of
	ficate or, pag	e Cor	25. Was case referred to medical				26. Place of Deat	1 Tes	2No No		2 X No
r VIII	r this certificate ha sral director, page 2	0 8	evaminer?	spital: 1 Inpatient	2 ER/Outpat	ient 3□ DOA Oth	ar.	me 5 Resid		ner (Specify	HOSPICE
In Of	offe June	on: T	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	z8b. Time	/ Wor	k?	28d. Describe h			
DIVISION I or Attanding after death.	the the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm,		Yes 2 □ No	28f. Location (S		ber or Rura	I Route Number,
al or A	Dira in b	Certification:	4 Homicide determined	building, etc. '(Sp	necify)	,,		City or Tow	m, State)		
DIVISION Of VITA To the Hospital or Attanding Physician: within 24 hours after death.	To the Funeral I		(Check only 2 Medical Examin	cian: To the best of my er: On the basis of exar	knowledge, de nination and/or	ath occurred at the tin	ne, date and place, pinion, death occur	and due to the d	cause(s) and m	anner as sta	ated. the cause(s)
the t	o tha l	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signe		
چ <u>ج</u>	k – ŏ		1800		ZU	Dog	5841		02-1		-
10	D	1	30. Name and address of person who con	pleted cause of death	(Item 23a) (Typ						
	Sta	10	31. Date filed (Month, Day, Year)	32. Paistrar's S	ignature	e. Print) Dww oo s	O CT.	SALIS	BUR	y M	0.21201
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 6 200	5 Streve	K.	Sports.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of Death	Reg. No	ngaan
	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Dete of Death Month Day Year	3. Time of Death
1	/Medi	cal	Wae Frances Kobin So 4e Fecility Name (If not institution, give street and number)	4b. City, Town, or Loca	ation of Death 4c. County of Death	12:36 HM
	Examir	ier	Ft. Washington Health & Rehabilitation	Center Fort Was	. 1 1),	eorges
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 1 Yrs. Usual Residence of Decedent	Months Days Hours Min	B. Date of Birth 9. Birth	place (State or Foreign intry)
	arylend show	. 1	10a. State 10b. County 10c. City, Town or	4		10d. Inside City Limits
	the Ma	ctor	MID Prince Georges Fort V	Vashington		1) Yes 2□No
	sath with the 23a or 2	Funeral Director	815 Stag Way	20744	10g. Citizen of What Cou	
21215-0020	72 hours efter death with the Maryland natural', or flems 23a or 28e-f show dical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes, 2 ☑ No It Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri Yes 2 No Specify: 	Black, White	
5-0	"natural",	eted	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired)	16b. Kind of Business/li	ndustry
2121	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	dHardler	Restaura	ant
	of filed of Hygi other	BeC	17. Father's Neme (First, Middle, Last)		First, Middle, Maiden Sumame)	
ylar	Mente Mente arked	JOE TO	Slade ErKins	Jenni.		
, Maryland	ges 1 end 2 should be filed within to filed welth end Mentel Hygiene. If flem 27 is marked other than or other traumatic event, the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem in the Mentel flem is the Mentel flem is the Mentel flem in the Mentel flem is		Edith Robinson/Daughter 815	Stag way Fort Wa	ushington, MD 20	70
Baltimore	semit. Peges 1 end 2 should be filed within Department of Heelith and Mentel Hygiene. Important: if Item 27 is marked other than may injury or other traumatic event, that Mades.		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	position (Name of rematory or other place) Valley Mem. Pk. 2	Date 20c. Location - City or T -19-05 Annundal	. Va.
Balt	permit. Pege Depertment of Important: if any injury or ance.		21. Signature of Funeral Service Licensee Nelson & Melson &	22. Name and Address of Facility Gree 314 Franklin St., Ale	ene Funeral Hoi Exandria, UA 223	
-			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Ceuse (Final		1	Criser and Death
	Examiner		disease or condition resulting in death) e. Demention Due to (or as a cons	sequence of):		
	Pa tim	iner	- Cerebrovase	ular Atherosc	lerosis	
	icete be executed physicien end s the buriel-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	equence of):		
68760,	rtificete be execui ng physicien end ses the buriel-trer	edicai	that initiated events C	equence of):	-	
Box 68	£ 20	2	resulting in death) Lest			
	death ce ne attendi ed for use	sicia	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23b. Did tobacco use contribute to	to the cause of death?
P.0	thet the ed by th deteche	Phy	Peripheral Vascular Disea	.se	1 □ Yes 2 No 3 □ Pro	obably 4 Unknown
Division of Vital Records,	v requires thet the death ce been signed by the attendi should be deteched for use	Completed by Physician/	Decubitus Ulcer		performed?	Vere autopsy findings vailable prior to completion of cause
Rec	The law ste hes t page 2 s	dmo				death? □Yes 21 7 ÍNo
ta	an: The	Be Co	25. Was case referred to medical	26. Place of Death (,	2010
× >	hysici his cer il direc	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati		e 5 ☐ Residence 6 ☐ Other (Speci	fy)
3 6	After the funera	Ë G G	27. Menner of Death ↑ Naturel 5 ☐ Pending ↑ Accident investigation 27. Accident investigation		d. Describe how injury occurred	
DIVISI	or Attending Physician: effer deeth. Director: After this certific in by the funeral director,	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide	street, factory, office 28	f. Location (Street and Number or Rur City or Town, State)	al Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours effect deeth. To the Funeral Director: Atter this certificate hes completely filled in by the funeral director, page 2	ledical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause(s) and manner as a at the time, date and place, and due to	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	
	4		Can the		4	
R	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type Edger V. Potter, Jr. M.D.: 1326	8 Southern Ave.#2	10 Washington, DC	20032
	Sta Registr		31. Dete filed (Month, Day, Year) FEB 1 7 2005	and the same of th		

DHMH 16 Rev 6/95

			1 - For Amend Ite	m 26 per o	larylan Ir.,G8	d / Dep 55,05/	artment of 1 04/06dht Tificate of	lealth Death	and M	lental Hy	/giene Reg. No.	005	069	91
	Obvoio	ş	1. Decedent's Name (First, Middle, I	Last)		-				2. Date of De	eath Day	Year	3. Time of	Death
	Physic /Medi		William	Ridd:	ick					Februa			12:25	A^{M}
	Exami	ner	4a. Facility Name (If not institution, g	nive street and number	r)		4b. City, Town,	or Location	of Death		4c. (County of Death		
			4605 Calais St. 5. Social Security Number 6	. Sex 7. A	an (In um	last histholass	Oxon Hi		r 24 Hrs.	0.0		nce Geo		
	Funeral Director		231-01-5178	1⊠M 2□F	90	Yrs.	Months Days	Hours	Min.	8. Date of Bi	1915	9. Birth Cou Be1h	place (State o intry) aven N(r Foreign C
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Ci	tv I imits
	Manyl f sho	ō	Va			rfolk							1 Tes	-
	the	Director	10e. Street and Number		1 110	TIOIR	10f. Zip Code				10g. Citiz	en of What Cou	ntry?	
	h with	0	2813 #B Early S	÷			23513							
	deat	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. \	Vas Decedent of I	dispanic O	rigin? (Spe	cify Yes or No		ed State 4. Race - Ameri	can Indian,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 22 is marked other than "natural", or items 23a or 28a-f show tiem 22 is marked other than "natural", or items 23a or 28a-f show othe Errannatic event, the Medical Errannatic per colling at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		No		f Yes, specify Cub ☐ Yes 2 No	an, mexica Specify		Hican, etc.)	5	Black, White Specify: Black		
9	2 hou	Completed	15. Decedent's			16a. Deced	lent's Usual Occup	pation			16b. Kind	d of Business/Ir	dustry	
215	within 7 ene. than "n	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	kind of work done OO NOT use retire	during mo: d)	st of workii	ng				
	od will rgien er th	Con	7			Main	tenance					ivate		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than "reumatic event, the Med	Be	17. Father's Name (First, Middle, La.							(First, Middle		Sumame)		
<u>y</u> la	ould Men Marke Marke	2	Jordon Riddic	••						1cCloud				
Na Na	12 sh h and l ls m		19a. Informant's Name/Relationship				g Address (Street					Town, State, Zij	Code)	
	1 and 1 Health Jem K		Howard L. Riddi 20a. Method of Disposition	ck / Son	20b. Pl	4605	Calais S	t 0xo		L1 Md 2		ation - City or Te	oum State	
Baltimore,	Pages nent of H int: If its iry or o		ta Burial 2 ☐ Cremation 3				sition (Name of patory or other place) Cemetery	ce)					JWII, State	
큹	permit, Pages Department of Importent: If it any injury or o	20a. Method of Disposition **Commetted by the commetted by the commetted by the commetted by the commetted by the commented						es of Facili	2-18-			lk Va		
Ba	permit. Departr Imports any inju		Valoria 1	ndla	N	A 2	Name and Addre 1exander 617 Penn	S. P Ave	ope E SE Wa	uneral	Home	20020		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	ed the death line.	. Do not ente	or the mode of dying	ng, such as	cardiac or	r respiratory a	rrest,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	_a. Prost	rate (Cancer							Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):								
		70	Sequentially list conditions, if any, leading to immediate	b Due to (or as	s a consequ	ence off-								
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	240 10 (0. 4.	0 0 00110042	01100 01).								
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):						-		
68760,	ficate be executed physician and is the burial-transit	cal		⊾ d										
_	- m -	ledical									-			
Вох	death certiff e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnancy	,			23	d. Date of delive	ery	
	0 0 0	sici	in the past 12 months? 1 Yes 2 No	4□Pregnant a 9□ Unknown			Other (specify)					Month	Day Y	ear
P.0	that the de led by the detached	Phy	9 Unknown			(a) 1- ab	4-4			Lon- Bids				
Vital Records,	Se 75 60	by	Part II. Other significant conditions	contributing to death i	out not resul	iding in the un	oenying cause giv	en in Parti				e contribute to the		
50	w require been sign	lete								24a. Was	20	24h Mora auta	nov findings a	variable
Re	0 5 0	ompleted								autop perfo	rmed?	death?	mpletion of cal	use of
ta	iclan: Th certificate rector, pag	e C	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	2□ No	
\leq	Physiclan: this certific ral director,	OB	examiner? 1 □ Yes 2 □ x No	Hospital: 1 Inpati	ent 2 🗆 E	R/Outpatient	3□ DOA Oth	er: 4 🗆 Nu				☐Other (Specifi	()	
J Of		T :uc	27. Manner of Death XXNatural 5 Pending	28a. Date of Inju	ury av Year)	28b. Time of Injury	28c. Injun Wor	at		8d. Describe h			,	
<u>Ö</u>	Attending ir death. ector: Afte by the fune	atic	2 Accident investigation	on				Yes 2□	No					
Division	after de Direct	Certification:	3 Suicide 6 Could not 4 Homicide determined	289. Place of in	jury - At hon tc. <i>(Specify)</i>		et, factory, office		21	8f. Location (S City or Tow	Street and f m, State)	Number or Rura	Route Numb	er,
	Hospital		29a. Certifier 1 Certifying P	hugieien. To the heat	of my leave	dada daab				41				
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination	on and/or inve	estigation, in my o	oinion, dea	id place, ar ith occurre	d at the time, o	ause(s) ar date and pl	ace, and due to	ated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of contified				29c. Licenso	number		- 2	29d. Date s	signed (Month, I	Day, Year)	
	1		Willer V. Va	my			D352	06			Febru	ary 14,	2005	
	(3)		30. Name and address of person who				,							
	Sta	10	William T. Tan 31. Date filed (Month, Day, Year)	ner MD 11/	01 Li	vingst	on Rd Ft	Wash	ingto	n MD20	745			
	Sta Registr	-	FEB 1 6 200			An	S)							

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FEBRUARY 7, 2005 8:25 A. ANNE RAUSEO Α. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MANOR CARE - DULANEY TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT - 7 , 1920 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🕅 F Months Yrs. Director 182-09-2194 84 PENNSYLVANIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 X Yes 2 No Director MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 0 or items 23a 8911 REISTERSTOWN ROAD 21208 U.S.A. deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours efter call Hyglene.
other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 X Widowed 4 □ Divorced WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT HOTEL/RESTAURANT permit. Peges 1 and 2 should be like Department of Heelth end Mental Hy Important; if Item 27 is marked oth any injury or pather traumatic event sine. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVID NICHOLSON MOLLIE LOWENTHAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM S. RAUSEO/SON 2716 SMITH AVE., BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 ▼ Removal from State

4 □ Donation 5 □ Other (Specify) KING DAVID MEM. GDN. 02/09/2005 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Donald (: - 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a RENAL FAILURE ENDSTAGE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSIVE NEPHROPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy tindings available prior to completion of cause of death? autopsy performed? certificate 2 X No 1 TYes 2 □ No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No ဥ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide hours efter To the Hospitel within 24 hours e To the Funeral I 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D56775 FEBRUARY 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER DRIVE, #208 TOWSON, MARYLAND 21204 RASHA MORAD, M.D., 31. Date tiled (Month, Day, Yeer) FEB 15 2005 32/Registrar's Signature State Registra

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		C	ertificate o	f Death		Reg. No.	
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De		3. Time of peath
	Physicia		Franklin Thorn	ton Pohor	ct a			Febru	ary 17.2	2005 0245
	/Medic		4a. Facility Name (If not institution, give		LS	4b. City. Town	, or Location of Dea		4c. County of	
	Examin	er			. 1		Easton			
				1 Hospita	1 ⊥ 'In yrs. last birthda	v) If Under 1 Yea		rs. 8. Date of Bir		Birthplace (State or Foreign
	Funeral			M 2□F 7. Age (Months Day				Birthplace (State or Foreign Country) MD .
	Director			90	,			6-24-	1914	St.Michaels,
	D .		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or	Location				10d. Inside City Limits
	sho	_	MD Talbot		Easton					1X Yes 2 □No
	8a-f	cto	MD 141200							
	라 다 10 m	Jire	10e, Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	15 wi	al	101 Third Have	n Heights	5	2160	1		USA	
	dea ms ms	by Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	B. Was Decedent o	f Hispanic Origin? uban, Mexican, Pue	(Specify Yes or No	14. Race -	American Indian, White, etc.
9	after or Ite	Fu	1 Never Married 2 Married	1√2 Yes 2 □ No If Yes, Give	WWII	1 ☐ Yes 2 ☐ N		, ,		
21215-0036	72 hours after death with the Maryland 'natural', or Itams 23a or 28a-1 show 'deal Examination must be couldled at		3 Widowed 4 Divorced	Year or Dates:	MMTT	I I les 2 LAY	о зреспу.		Specify: I	Black
9	2 ho	Completed	15. Decedent's Ed		16a. Dec	edent's Usual Occ	upation ne during most of w	ndkina.	16b. Kind of Busin	ness/Industry
품	nin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use reti	red)	orking.	Private	e Estate
=	iene.	Eo	11 Years	College (1 401 01)		atakor/	Gardner		TIIVAC	. Ibcacc
	filed Hygid Sther		17. Father's Name (First, Middle, Last)		Car	scaner/	18. Mother's N	ame (First, Middle	, Maiden Sumame)	
an	d be ental	Be	Isaac Roberts				Ella	France	s Bailey	7
\leq	2 should be and Mental Is marked o aumatic eve	2	19a. Informant's Name/Relationship (7	vne Print)	19b Ma	iling Address (Stre	et and Number or I	Bural Boute Numb	er, City or Town, St.	ate Zin Code)
Maryland	12 s h an 7 Is trau		Roman Roberts (•		7/				n,Md. 21601
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "natural; or Itams 23a or 28a-f show other traumatic event, the Medical Examination must be notified at		20a. Method of Disposition	Nephew)				Date	20c. Location - Ci	
0	Pages Inent of Hant: If ite			Removal from State	1	position (Name of rematory or other p				
Ē	nit. Pag bartmen cortant: injury :		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Thomas	Memoria	$a\perp 2-2$	23-2005	St.Mich	naels, MD
Baltimore,	permit. Pages Department of Important: If it any injury or one		21. Signature of Funeral Service Licen	599	1	22. Name and Add	fress of Facility	lov Fun	eral Hom	no DC
00	Dep Imp any		Fr. Carrol	1 Husli	0-19			_		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	ne de ath. Do not é	nter the mode of d	ying, such as cardi	ac or respiratory a	rrest, r	Interval Between
	Distriction	. 1	Immediate Cause (Final	and a		to same in	Jane			Onset and Death
	Physician / /Medical	ľ. II	disease or condition resulting in death)	a. Cerebre	consequence of):	n acci	Deni			
10	Examiner			Due to (or as a	consequence on:	- A -				
н		-	Sequentially list conditions	b. Due to (or as a	consequence of):	1011				
	ed sit	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1	1 2 to.				
	ecut and -tran	Examiner	that initiated events resulting in death) Last	c. Conges	consequence of):	17 001	uce			
80,	oe ex			500 10 191 43 4 1	consequence on.					
68760,	certificate be executed utility by sicien and use as the burial-transit	v/Medicai		d						
	ng p	Nec	IF FEMALE:							
XO			23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		B⊟Ectopic pregnar	ncy		23d. Date of	,
m.	death le atter	ici	in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant at tir 9 Unknown		Other (specify)			Month	n Day Year
o.	w requires that the death been signed by the atte should be detached for	Completed by Physicia	9 🗆 Unknown	9LI OTIKITOWIT				-		
S, P	s tha	ΥP	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause	given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
ds.	uire sig ld bl	D	Hurstinden	a				10	Yes 2 No 3	Probably 4 Unknown
Ö	v req beel shou	ete	20					24a. Was	an 24b We	ere autopsy findings available
3e(a o o	mp						auto	psy prio	or to completion of cause of ath?
=		ပိ						1 ☐ Yes		Yes 2□No
of Vital Record	Phyeiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hagnital				eath (Check only	one)	
=	di S	2	1 L Tes 2 K NO	Hospital: 1 Nnpatient		ent 30 DOA		***************************************	dence 6 □Other	
2	ng P fter t nera	ü	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time		jury at vork?	28d. Describe	how injury occurred	
.0	Attending It death. ector: After by the fune	ati	2 Accident investigation			M 1	☐Yes 2☐No			
Division	l or Attence after death Director:	ij	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	· At home, farm, (Specify)	street, factory, offic	Э	28f. Location (City or To		or Rural Route Number,
	Hospitel or A 24 hours after Funerel Dire tely filled in b	Certification:		,					,	
	hour nere y fille			ysicien: To the best of						
	He Ho	edicai	(Check only 2 Medical Exert	niner: On the basis of e and manner state		investigation, in m	y opinion, death oc	curred at the time,	date and place, and	I due to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	Λ		29c. Lice	nse number		29d. Date signed (i	Month, Day, Year)
			Hariala C	DIA. // 11.	Λ	De	00597	-62	02/17/	05
•			30. Name and address of person who	completed dayse of dea	th Hem 23a) (Tun	e Print)			- ' ' ((
			11 A CALON C	n m	,	Facil	an, was) 242 =		-
	Cto	tà	31. Date filed (Month, Day, Year)	32. Registrar	s Signature _		11/1	- 219 S.	. Washin	gton St.
	Sta	ne	EED 1 9 2005	Anna A	po A	All .				

DHMH 17 Rev 1/2001

Franklin T. Roberts

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Christian Lewis Rust February 8, 2005 4:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2□ F 554-38-7651 75 Yrs Philippines Director May 17, 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in then "natural", or items 23e or 28e-f show the Medical Examinar must be multiplied at 1 ☐ Yes 2X No Directo Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7020 Upland Ridge Drive 21710 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No 1946-47
If Yes, Give
Year or Dates: 1951-53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. important: if itam 27 is marked other than "nx any Injury or other traumatic evant, the Madia once. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Vice President Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert Carl Rust 2 Mary Elizabeth Panniman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy H. Rust, wife 7020 Upland Ridge Drive, Adamstown, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2/9/2005 Smithsburg, Maryland 22. Name and Address of Facilit Keeney and Basford Funeral Home 21. Signature of Funeral Service Licenses M00999 106 East Church Street, Fred 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. M00999 106 East Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) tanciente ? /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the 88 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown by the 9☐ Unknown n signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No rmed? 2 No certificate 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D0058762 February 9, 2005 A of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Warren, MD, 1564 Opossumtown Pike, Frederick, Maryland 31. Date filed (Month, Day, Year)

Registrar

2005

	•		State of Maryland / Department of Health ar State of Maryland / Department of Health ar Certificate of Death		tal Hygi	•	06996
	Physici	an	Decedent's Name (First, Middle, Last)	M	ate of Death Month	Day Year	3. Time of Death
	/Medio Examin	al	JOAN MARIE SEIBERT 4a. Fecility Name (If not institution, give street and number) ST. MARY'S NURSING CENTER LEONARDTOWN		B. 22	4c. County of Deat	
15	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 2 Year Months Days Hours	4 Hrs. 8. Da	ate of Birth Month, Day, 1 LY 23	(ear) 9. Birtl	IARY 'S Inplace (State or Foreign untry) SSACHUSET'
Maryland 21215-0036	s I and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hyglene. I Heath and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23e or 28a-f show other traumatic event, I'm Medical Examinar must be rediffed at)ire		of working s Name (Firs. E L L E	res or No- t, etc.)	City or Town, State, Z	rican Indian, e, etc. ITE Industry ERNMENT
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item any injury or other once.		20a. Method of Disposition 1 Burial 2D Cremation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITIAN CREMATORY 2 21. Signature of Funeral Service Licensee MO0479 22. Name and Address of Facility RAYMOND FUNER	Date 2 - 2 4 - 6	05 A	C. Location - City or I	Town, State
1760,	/Medical Examiner portion and portion its principal its pr	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of imjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	RYLAN)	D 20	646	Approximate Interval Between Onset and Death
, P.O. Box 68	w requires that the death certificate is been signed by the attending physishould be detached for use as the t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) Other (specify) Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II.	2	3e. Did toba	23d. Date of deline Month	Day Year
Vital Records	The lar ate has page 2	Completed b		-	4a. Was an autopsy performe	24b. Were aut	obably 4 Unknown opsy findings available ompletion of cause of
Division of Vita	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be (examiner?	28d. D	5 ☐ Residend Pescribe how	ce 6 Other (Specingury occurred et and Number or Rui State)	
	To the Hospital or A within 24 hours after within 24 hours after To the Funeral Direct Completely filled in by	Medical	24035 THRHE NOTCH RW., HOLLYWOOD, MD 20636	place, and du occurred at the	he time, date	se(s) and manner as a and place, and due to . Date signed (Month,	to the cause(s) Day, Year)
DH	Registr	- 12	MAR 0 2 2005 Seems & Spales				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 06997 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year HATTIE FEBRUARY 7, /Medical SEIFERT 8:15 P M 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BROOKE GROVE NURSING HOME SANDY SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 M 2 F 97 Yrs. Director 063-16-9936 JAN 15, GERMÁNY Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location im 27 is marked other than "natural", or Itams 23a or 28e-f show her traumatic event. Its Madical Examiner must be notified at 10d. Inside City Limits MARYLAND MONTGOMERY SILVER SPRING Directo 1 ☐ Yes 2X No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 CHISWICK COURT #10 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after de It Hygiene. other than "natural", or Itam Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No WHITE þ Specify 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury out ther traumatic event. Its once. 12 BOOKKEEPER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) AKIVAH ROSS ROSALIE ROSENSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALD SEIFERT/SON 9511 McDOUGALD ROAD, BROADWAY, NC 27505 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State ¹ 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEML GARDENS 12/11/2005 OLNEY, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the bath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death tmmediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) **TMMEDIATE** /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 YEARS Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2X No ŏ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Compieted page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 XNo of Vital 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: ٩ 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 XNatural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide

within 24 hours a To the Funeral L

31. Date filed (Month, Day, Year) 1 4 2005

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

State

Registrar



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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24543

29d. Date signed (Month, Day, Year)

20906

FEBRUARY 8, 2005

			For	State of Mai			artment of			•	ne	•
		•	1 - For State Registrar			Ce	rtificate of	Death		Reg.	Not) O O C	. 00000
	Physicia	212	Decedent's Name (First, Middle, Last)			<i>()</i>	/ /	/		ate of Death	Day Year	3 Time of Death
	/Medic		Ruse			5 4	, Ndel	/			7, 2005	10:00 A ^M
	Examin		4a. Facility Name (If not institution, give s				4b. City, Town,		of Death		4c. County of De	
	Funeral		VASHINGTON ADVENTIS 5. Social Security Number 6. Sex		(In yrs. last	birthday,	TAKOMA I	r If Under	24 Hrs. 8. D	late of Birth Month, Day, Ye	MONTGOME 9. B	KY irthplace (State or Foreign Country)
	Director		196-24-1267 ^{1□}]M 2∏F	95	Yrs.	Months Days	Hours	Min. APR	RIL 8,		LAND
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or L	ocation					10d. Inside City Limits
	Manyla f sho	ŏ	MARYLAND MONTGOMER		SILVEF							1X Yes 2 □ No
	r 28a-	Directo	10e. Street and Number	.1	JILVIII	CDII	10f. Zip Code			10g.	Citizen of What (Country?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Madical Examiliar must be indiffed at	alD	722 WHITAKER TERRAC	E			2090)1			U.S.	Α.
	tems	Funeral	The manual dialog	12. Was Decedent Ev Armed Forces?		13.	Was Decedent of If Yes, specify Cul	Hispanic Original Hispanic Origin Hispanic Origina Hispanic Origina Hispanic Origina	gin? (Specify) n, Puerto Ricar	Yes or No- n, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:)		1☐ Yes 2█ No	Specify:			Specify: W	HITE
9	2 hou atura	ted l	15. Decedent's Edu	cation	1	6a. Dece	dent's Usual Occu	pation	A of wordsing	168	o. Kind of Busines	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	-)	life.	kind of work done DO NOT use retir	ed) ed)	t or working		01111 H014	
2	filed wi Hygien other th		12	<u> </u>		HOMI	EMAKER	19 Matha	ela Nama /Fira	st, Middle, Mai	OWN HOME	
and	ntal Hed ot	o Be	17. Father's Name (First, Middle, Last) GERSHON	ZILBERO	ንጥ			MALA	a s Name (r//s		IOSZ	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show ammatic event, the Madical Examilinar mant be indiffied a	Ĕ,	19a. Informant's Name/Relationship (Ty			9b. Mail	ing Address (Stree		er or Rural Rou			, Zip Code)
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic events.	1	FRED SHINDELL/HUSBA	ND	7	722 V	VHITAKER	TERR.	, SILVE	ER SPRI	NG, MD 2	0901
Baltimore,	of He ritem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place ceme	of Disp	osition (Name of matory or other pla	ace)	Date	200	c. Location - City o	or Town, State
Ĕ	Pages ment of I		'4 □Donation 5 □ Other (Specify)	emovat nom State	JUDEA		M. GARDE				NEY, MAR	
3all	Depart Depart Import any in		21. Signature of Funeral Service License	/ 1		D_{i}^{2}	2. Name and Addr ANZANSKY- L70 ROCKV	ress of Facilit -GOLDBI	ERG_MEM	ORIAL	CHAPELS,	INC.
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Ċ.	P		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	0			,		,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequen	ce of):	mmot	ma				5 Days
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89	ificate g phys		350		,							
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of 1 Live birth 2			□Ectopic pregnani	cv			23d. Date of d	
O. B	e deal he att	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at ti 9☐Unknown			Other (specify)				Month	Day Year
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COL	w require been si should	Completed								24a. Was an	24b. Were	autopsy findings available
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<u>ra</u>		BeC	25. Was case referred to medical					26. Place	of Death (Che			
of <	Attending Physician: r death. ector: After this certification the funeral director.	To	examiner?	lospital: 1 Inpatien		Outpatie	nt 3 DOA				e 6 □Other (Sp	pecify)
o LC	ding P. After t	ion:	27. Manner of Death Natural 5 Pending	28a. Vate of Injury (Month, Day		b. Time o Injury	W	uryat ork? ⊡Yes 2.⊡I		Describe how i	injury occurred	
Division	death death ctor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	rv - At home	, farm, si			28f. L	ocation (Stree	t and Number or i	Rural Route Number,
<u>≤</u>	after after Direct	ertii	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	, ,	,			City or Town, S	itate)	
	Hospital or 24 hours afte Funeral Dire tely filled in t		29a. Certifier Sertifying Physical Exami	sician: To the best of	my knowle	dge, dea	th occurred at the	time, date an	nd place, and d	lue to the caus	e(s) and manner	as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	ledicai	one)	ner: On the basis of e and manner state		and/or if	^		ar occurred at			``'
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	~		33 Name and address of person who co	\sim \sim $e^{//}$	8 31 C		ress for ()	Pauler	rand a	Gast	5,1 ve	-SAVING.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pegistrar	r's Signature	1	backet				manyl	and 20903
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			Decedent's Name (First, A.	fiddle, Las	t)								2. Date of De.	ath	3 4 4 4 4 C		me of Death
	Physici: /Medic		Clifford A.	Snead									Month Februar	v 1	•		23 A M
	Examin		4a. Facility Name (If not instit			ımber)			4b. City, To	own, or	Location of	f Death			. County of De		
			Laurel Regio						Lau						ince Ge		
	Funeral		5. Social Security Number	6. Se	ex ☑M 2□F	7. Age (In	yrs. last bi	irthday) Yrs.	If Under 1 Months I	Year Days	Hours Hours	Min.	8. Date of Birt (Month, Da			irthplace (Si Country)	tate or Foreign
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	ow ow		10a. State 10b. Co			10	c. City, Tov	vn or Lo	cation							10d. Insi	de City Limits
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	or 28¢	Director	10e. Street and Number	irr.gon	ier y	1	DILV		10f. Zip C					10g. Ci	tizen of What (Country?	
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20	or li	by Ft	1 Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo		1 ⊠Yes If Yes, G	2 ☐ No ive			1 ☐ Yes 25	No.	Specify:				Specify:		
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Σ.	and and n 27		Dennis C. Mc	Adoo	N	ephew					od Ço		Laurel				
Baltimore	of Hill itar		20a. Method of Disposition 1 Burial 2 Crema	tion 3 🗆	Removal from	State	cemete	ary, crer	sition (Name natory or other	er place		C	ate	20c. L	ocation - City o	r Town, Sta	ite
Ē	Pag Iment		° 4 □ Donation 5 □ Oth	er (Specify)		Arlin Cem	Pto	n Nati ry		मः	eb.2	2,2005	Ar1	ington,	Virgi	nia
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ŏ	th ce tendir	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnan	ıt	23c. If yes, ou 1□Live	tcome of p		h 3[Ectopic preg	gnancy					23d. Date of d		Voor
E		sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Preg 9□Unki	nant at time	of death	5	Other (spec	cify)				•	Month	Day	Year
л Э	requires that the de been signed by the a hould be detached f	Phy	Part II. Other significant cor	ditions of	antributing to	death but no	nt secultine	in the m	nderhing cau	ico anio	n in Part I		23e Did to	hacco	use contribute	to the cause	a of death?
S,	ires ti signe d be d	by	Acute Rena			Joan Dai no	A rosaning	111 (110 (1	naony ing caa	136 give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				□No 3□F		
cord	req	etec	110000 110110														
ě	has has	Completed											24a. Was autop perfo		prior to death?	completion	ings available of cause of
<u></u>	ician: The certificate ha		05 111	411									1 ☐ Yes	2 🙀 No		s 2 No	
VII	Physician: this certific ral director,	o Be	25. Was case referred to me examiner? 1 \sum Yes 2 \sum No	-	Hospital:	Inpatient	2 X EB/O	utnation	it 3□ DOA	Othe			ne 5 ☐ Resid		6 FlOther (Co	agifu)	
O	Phys er this eral di	J	27. Manner of Death			of Injury		Time of		c. Injury Work		-	28d. Describe h			ecity)	
slon	nding I rth. :: After e funer	atlo	1 Natural 5 Pe	ending vestigation		ntn, Day Ye	ar)	Injury	м		? /es 2 □ l	No					
<u> </u>	al or Attending F after death. I Director: After d in by the funer	tifica	3 ☐ Suicide 6 ☐ C	ould not be etermined	289. Plac	e of Injury - ding, etc. (S	At home, f	arm, str	eet, factory, o	office		1	28f. Location (S City or Tox	Street ar	nd Number or F	Rural Route	Number,
5	tel or rs afte al Dir	Certification:			Dunc	anig, oto. (c	poorty						0, 0	, oluit			
	o the Hospitel ithin 24 hours a o the Funeral (edical	(Check only 2 Med										and due to the o				use(s)
	the h in 24 tha F plete	Aedi	one)		and mai	nner stated.											
	中華や教	Σ	29b. Signature and title of ce	II (III legr					29c. l	License	number			zad. Da	ite signed (Mor	ип, Day, Ye	ar)
,	231		1/10	od		ds)				2929	93		F	'ebr	uary 10	,2005	
		1	30. Name and address of pe					. ,,	,	-	1 " 0	00 -	• • • •		3.57	00010	
	Sta	tá	Michael A. L 31. Date filed (Month, Day, 1	(ear)	n, M.D	Registrar's	UU FO Signature	res	Glen	Ka	oa #2	UU_S	ilver S	pri	ng,MD	20910	
	Registi		FEB	L 4 20	05	Registrar's	K.	60	all								
					-			-/-									

		•	For Stete Registrar	State of Mar	yland / l		tment of Herificate of L		d Mental Hy	/giene Reg. No:	41-	07000	
			Decedent's Name (First, Middle, Last		2. Da			e of Death 3. Time of Death					
	Physicia		MAX		Month FEBRUAR			Y 7, 2005 11:50 A M					
	/Medic Examin		4a. Facility Name (If not institution, give	STEINBE street and number)		4	4b. City, Town, or	Location of D			County of Death		
	<u></u>		HOLY CROSS NURSING AND REHAB. CTR. BURTONSVILLE MONTGOMERY									Z	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, L			Birth 9. Birthplace (State or Foreign Country)			
	Should be filed within 72 hours after death with the Maryland and Mental Hygiens are Mental Hygiens is marked other than "natural, or Items 23a or 28a-f show the unafter event, I to Medical Examinational Promities and one of the control of the medical Examination of the control of the contr		098-07-9007 1XDM 2□F 89 Yrs.			Yrs.	MAR.			19, 1915 NEW YORK			
			Usual Residence of Decedent 10a. State 10b. County	vn or Loca	ation			10d. Inside City Limits					
		5					1X Yes 2 □ No						
		Director	MARYLAND HOWARD 10e. Street and Number	JMBIA	10f. Zip Code			10a Citi	zen of What Cou	intni?			
							21045					y.	
e, Maryland 2121		eral	7110 MINSTRAL WAY				Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				U.S.A. 14. Race - American Indian,		
		Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖸 No	7,				uerto Rican, etc.)		Black, White, etc.		
		by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No Specify:			Specify: WHITE			
		Completed	15. Decedent's Edu	College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			working	16b. Ki	o. Kind of Business/Industry		
		ple	Elementary/Secondary (0-12)						Working				
		Con	2 OPTICIAN								PTICAL		
		To Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middl	e, Maiden	laiden Surname)		
			ELIAS STEINBERG SA										
			19a. Informant's Name/Relationship (T						r Rural Route Num				
	1 and 2 Health tem 27 l		ELLEN L. LAUPUS/DA	AUGHTER				AR CHA	SE, COLUN	1			
	Pages 1 nat: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X	Removal from State	cemete	e of Disposition (Name of etery, crematory or other place)		9)	Duit	200. 20	c. Location - City or Town, State		
Ē	permit. Pag Department Important: I any injury o		' 4 □ Donation 5 □ Other (Specify,		KING D				/09/2005	FALL	LS CHURC	H, VIRGINI	
Ba	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	De dans		ED		EL FUN	ERAL DIRE				
	0 D = 8 0		- umanda	ruceury	that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate								
			shock, or heart failure. List only of	one cause on each line	ne deam. Do	not enter	the mode of dying	J, such as car	diac or respiratory	arrest,		Interval Between Onset and Death	
	Priysician	3 3	Immediate Cause (Final disease or condition HYPERTENSIVE CARDIOVASCULAR DISEASE										
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):							
		<u>_</u>	Sequentially list conditions,	b. Due to lor as a	Due to or as a consequence of :								
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	onsequence of.									
	and al-trar	xan	that initiated events resulting in death) Last										
8760,	law requires that the dea h certificate be executed as been signed by the attending physician and 2 should be detached to use as the burial-transit												
587		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of Month 2 Pregnant at time of death 5 Other (specify) 23d. Date of Month 23d. Date											
Box (/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 \(\text{Live birth} \) 2 \(\text{Fetat death} \) 3 \(\text{Ectopic pregnancy} \) 4 \(\text{Pregnant at time of death} \) 5 \(\text{Other (specify)} \)						23d. Date of delivery			
ň		cla	in the past 12 months? 1 ☐ Yes 2 ☐ No							Month Day Year		Day Year	
Records, P.O.		hys	9 ☐ Unknown										
		by P	Part II. Other significant conditions co	23e. Did	23e. Did tobacco use contribute to the cause of death?								
	quires in sign uld be	pa	CEREBROVASCULAR INSUFFICIENCY							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xi Unknown			
	The ate h	Completed								24a. Was an 24b. Were autopsy findings avai			
Ÿ		E O								opsy formed? 2 X No	death?	2□ No	
		ø	25. Was case referred to medical					26. Place of	Death (Check only				
	8 w 70	To B	examiner? 1 □ Yes 2 🎇 No	Hospital: 1 ☐ Inpatien	t 2 ER/O	Outpatient	3□ DOA Othe	er: 4 🔀 Nursii	ng Home 5 Re	sidence (6 □Other (Spec	eify)	
	Jing After fune	1.0	27. Manner of Death	28a. Date of Injury (Month, Day	28b.	Time of	28c. Injury Work	28d. Describe	28d. Describe how injury occurred				
		atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	n			M 1 Yes 2 No						
Vis	Atte	tific	3 Suicide 6 Could not be determined				reet, factory, office		281. Location City or T	281. Location (Street and Number or Rural Route Num City or Town, State)		ral Route Number,	
ā	tal or rs after al Dir	Certification:											
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time,									
	ompl	Me	29b. Signature and title of certifier	A	1		29c. License	number		29d. Date signed (Month, Day, Year)			
)	1		De la la la la la la la la la la la la la				D52261			FEBRUARY 8, 2005			
	7		30. Name and address of person who	D52261									
			ALAN R. SEGAL, M.I	/				SPRING	, MD 2090	16			
	St	atė	31. Date filed (Month, Day, Year)	32 Registrar		dos							
	Regist	rar	FEB 1 4 20	115 Mare	10.	No. of Street, or other Persons							